Queensland Mental Health Commission

Submission to the

Inquiry into the opportunities to improve mental health outcomes for Queenslanders

Mental Health Select Committee

February 2022

Queensland Government

About this submission

This submission forms a component of the broader Queensland Mental Health Commission's (the Commission) overall submission to the Mental Health Select Committee Inquiry into the opportunities to improve mental health outcomes for Queenslanders. The focus of this submission is on *mental health funding models in Australia*

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Acknowledgement

We pay respect to Aboriginal and Torres Strait Islander Elders, past and present, and acknowledge the important role of Aboriginal and Torres Strait Islander people, their culture, and customs across Queensland.

We also acknowledge people living with mental health and alcohol and other drug problems, as well as those impacted by suicide, and their families, carers and support people. We can all contribute to an inclusive and respectful society, where everyone is treated with dignity, focused on wellness and recovery, and leads flourishing lives.

We acknowledge the professionalism and dedication of the broader mental health and alcohol and other drugs workforce and their concerted efforts to support the quality-of-life outcomes for all Queenslanders.

State and Commonwealth mental health funding for Queensland: impacts and implications

- Funding mechanisms are a key lever and control for improving service capacity and improvements, as well as service system mix and design.
- The effectiveness of funding as a lever of improvement and reform requires clarity and agreement about intergovernmental and cross-sectoral responsibilities for funding as well as decision-making about what is funded.
- As a result of the complex nature of Commonwealth-State relations, a fragmented landscape of service providers across Commonwealth and State government, private, primary health, and non-government organisations exits.

Funding responsibilities

- Responsibilities for planning, funding, and regulating mental health services is shared between Commonwealth and State government.
- Broadly, the Commonwealth has responsibility for funding primary healthcare through general practitioners and other allied health professionals.
- It also provides mental health services for veterans through the Department of Veterans' Affairs, a range of psychosocial support and treatment services commissioned through Primary Health Networks and directly funding non-government organisations (NGOs) for community and social support programs (including suicide prevention and early intervention treatment services).
- The State government funds specialist mental health alcohol, and other drug treatment and support services through service agreements with the Hospital and Health Services and NGOs.
- This includes a range of bed-based services in hospital and communities, community treatment services as well as community support services.
- Traditionally, the role of Commonwealth and State governments centres upon the primary healthcare sector treating high prevalence mental health conditions such as anxiety and depression, while the public mental health services focus on treating those with severe mental illnesses.
- Private-sector providers, including psychiatrists and allied professionals and bed-based mental health services are available in private hospitals.
- Though not addressed here, it must be recognised that the significant non-health expenditure through income support, aged care, disability, housing, employment, education, and justice as essential elements of the mental health and wellbeing support system.

How is funding administered?

Public sector

- Commonwealth funding is paid directly to HHSs through Pool accounts managed by the National Funding Body (NFB), based largely on the volume and mix of services delivered through HHSs by a system known as Activity Based Funding (ABF).
- ABF funding provides a mechanism for driving efficiency and quality mental health services based on a payment system centred on the number and mix of patients.
- A total of $429 million was paid to Queensland HHSs in 2019-20 from the Commonwealth National Funding Body pool.
- This represents about 40 per cent of spending on all clinical (admitted and non-admitted) mental health services delivered by Queensland HHSs.
- The appropriateness of ABF funding models for mental illness is contested as there are significant variations in the treatment of people with similar levels of need which mostly stems from the disparities in service landscapes and operational environments of hospitals – rather than any differences in the clinical presentation of individuals.
- Currently, specialised community ambulatory mental health services are not funded through an ABF model rather they are block funded.
- This means that despite needed growth in the specialised community ambulatory mental health sector (community mental health services provided through public mental health services), there are no incentives in place for these services to grow nor to increase productivity.
- Across Australia, only about 29 per cent of clinical staff time at community mental health services was spent on consumer-related activities, which falls short of the benchmark target of 67 per cent[1].

Primary health

Mental health services subsidised through Medicare

- Primary health care services are funded through Medicare subsidies for GPs, allied health, and psychiatrists.
- Funding is based on mental health and other items prescribed in the MBS schedule, with the length of consultation primarily determining the funding level.
- The time-based structure of MBS payments does not fit well with the evidence on ideal models of care for mental health conditions. For example, Medicare items do not pay for time spent collaborating with other providers – which is an essential component of best practice when treating complex mental health conditions.
- Medicare is a private practice model and is market-driven, subjecting it to significant service gaps and disincentives the provision of mental healthcare particularly for patients with chronic or complex conditions.
- The Commonwealth indexation of MBS fees for service has not kept pace with real increases in practice costs, contributing to increasing levels of out-of-pocket costs for consumers. This creates a tangible barrier to access for many consumers and impacts the viability of general practice, particularly in rural and regional areas.

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

Mental health services commissioned through Primary Health Networks

- The Commonwealth funds a range of mental health services through Primary Health Networks (PHNs) for a range of clinical and non-clinical supports across the mild, moderate, and severe ends of the spectrum.
- Services are funded through the Primary Health Network Mental Health Care Flexible Funding Pool through a process of commissioning, which is based on an assessment of the population health needs of a region.
- In addition to this, funds are also quarantined for Headspace, Headspace Early Youth Psychosis services, mental health services for Aboriginal and Torres Strait Islander peoples, and other trials and national projects according to a historical arrangement or on a fixed grant basis.
- There is an interaction between MBS rebated services and primary mental health services funded through PHNs stemming from overlaps in service provision across the two funding sources.
- The uncapped nature of MBS funding invites cost-shifting whereby services funded by the PHN are incentivised to allow MBS-rebated services to take the place of the services they would otherwise fund.
- In addition, alcohol and other drug services are commissioned through Primary Health Networks via the Australian Government Department of Health, primarily through the *National Ice Action Strategy* rollout.

Non-government sector

- State government funding to NGOs is allocated through the Department of Health through service agreements.
- These services are for a range of psychosocial supports and services in the community designed to complement specialised mental health services, especially for those in the moderate to severe ends of the spectrum who are not eligible for the NDIS.
- The Commonwealth also funds NGOs through PHNs to deliver psychosocial supports as part of the National Psychosocial Support (NPS) measure to people who are not eligible for support through the NDIS.
- State government funding to NGOs for alcohol and other drug services differs from funding for NGO mental health services. The Department of Health funds the NGO service system to provide alcohol and other drug treatment services across a range of treatment types, including specialist treatment and support services. Alcohol and other drug treatment services are also delivered by HHSs.

Private sector

- The private sector currently provides treatment for high-prevalence mental health conditions, particularly depression, anxiety, personality, eating disorders and drug and alcohol addiction.
- Private-sector services for inpatient psychiatric treatment or drug and alcohol treatment inpatient hospital stays are funded through private health insurance.
- Individuals purchase private hospital insurance to cover the cost of hospital accommodation

and a portion of the medical fees.

- Extras/ancillary insurance covers out-of-hospital treatments that are not eligible for MBS rebates (such as psychology). Gap payments are usually required.
- The private health insurance market is tightly regulated by the Commonwealth. Currently private health insurers are not able to fund MBS mental health services outside of hospital. This is despite evidence showing many mental health services for high prevalence conditions could be effectively provided in the community and could prevent people from requiring hospitalisation.
- The Commonwealth government funds a 30 per cent rebate on private health insurance premiums to all persons on a means-tested basis. The Commonwealth estimate that of the mental health share of the total private hospital revenue earned through the provision of psychiatric care is 5 per cent.

What funding is allocated?

Public sector

- Over the past 20 years, the mental health-related expenditure has more than tripled ($3.1 billion in 1992-93 to $11.0 billion in 2019-20) however spending as a proportion of health expenditure has remained unchanged and is growing at a slower rate, despite the significant number of mental health inquiries, recommendations, policies, and plans.
- The total State government expenditure on mental health services was $1.26 billion in 2019-20 (this **does not** include funding for AOD services or funding administered by A&TSICCHOs).
- The bulk of the funding was allocated to community treatment and acute hospital services.
  - community ambulatory services: $592 million (46 per cent),
  - acute admitted services: $394 million (37 per cent),
  - community residential: $70.9 million (6 per cent),
  - psychosocial support services delivered through NGOs: $50.7 million (4 per cent).
- **Whilst not generally published, a more accurate reflection of the true expenditure on mental health services is closer to $2.03 billion (see Table 1).**
- Of the $2.03 billion total:
  - Commonwealth share is $1.2 billion. This includes a contribution for clinical services under the National Health Reform Agreement, MBS and PBS services, a range of Commonwealth-funded programs and initiatives (including funding to PHNs), programs delivered under the Department of Social Services, and the Department of Veteran Affairs, national suicide prevention programs and other initiatives.
  - State share is $833 million. This includes inpatient, subacute and community ambulatory treatment services provided through public mental health services.

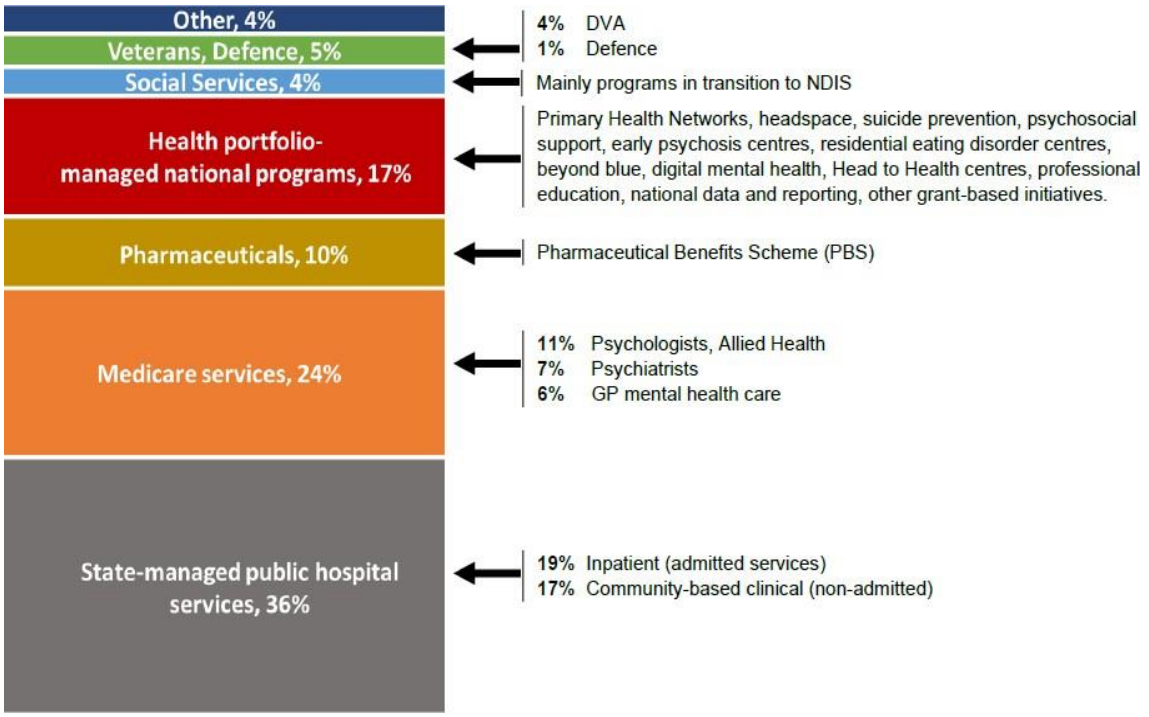
Table 1: Mental health spending in Queensland, adjusted for source of funds, 2019-20 ($millions)[2]

Commonwealth sourced			Queensland Government sourced			Total
	$ million	Per cent		$ million	Per cent	
Payments for State managed public mental health care – NHRA and DVA combined	434.9	36.2%	Inpatient care	245.7	29.5%	
National programs administered through Health, Social Services, Veterans Affairs and Defence portfolios	294.3	24.5%	Community mental health care services (clinical)	389.3	46.7%	
National Suicide Prevention Program	13.6	1.1%	Residential mental health services	70.9	8.5%	
Indigenous social and emotional wellbeing programmes	12.5	1.0%	Grants to non-government organisations	50.7	6.1%	
Medicare Benefits Schedule	284.6	23.7%	Other indirect expenditure	76.6	9.2%	
Pharmaceutical Benefits Scheme	121.8	10.1%				
Private Health Insurance Premium Rebates	36.2	3.0%				
National Mental Health Commission	2.4	0.2%				
Total expenditure	**1,200.3**	**100.0%**		**833.3**	**100.0%**	**2,033.6**

- Taking an all-governments, whole-of-Queensland perspective on mental health funding, the **Commonwealth contributes 59 per cent of total government outlays on mental health with the State funding 41 per cent.**
- More than one third (38.5 per cent) of Commonwealth spending is administered through four portfolios (Health, Social Services, Veterans Affairs and Defence), with the largest component (83 per cent) being health administered.
- The lack of detailed data made available in Commonwealth reporting limits the extent to which large funding bundles can be mapped to services on the ground or specific regions in Queensland.
- Figure 1 summarises the picture that can be built from Commonwealth data released to the public domain.

[2] Buckingham Consulting, February 2022; *Estimating the relative contributions of State and Commonwealth funding formental health in Queensland, 2019-20*

Figure 1: How Commonwealth funding is spent in Queensland, 2019-20



- Payments through the National Health Reform Agreement to Queensland HHSs for the operation of specialised mental health services represent about one third (36 per cent) and is the largest component of Commonwealth outlays.
- Payments for mental health-specific services delivered through the two programs – Medicare (MBS) and the Pharmaceutical Benefits Scheme (PBS) – make up approximately another third (34 per cent) of the total.
- These are demand-driven, universal entitlement programs that provide the foundation for primary mental health care.
- MBS spending on mental health has been growing steadily since the introduction of the Better Access initiative, funding psychologists and allied health professionals who now account for the largest share of overall MBS mental health spend.
- Activities administered through the Commonwealth Department of Health (17 per cent of total) are many and varied and funded on a grant basis to organisations across Australia. Spending in this category has also grown considerably.

Primary health

- Nationally, Commonwealth Health administered programs are estimated to amount to $189 million for Queensland. Services commissioned through funding of the seven Queensland Primary Health Networks is estimated to account for more than half (up to 60 per cent), with the remainder directed to a wide range of other activities, including digital mental health, psychosocial support for legacy clients of pre-NDIS programs, mental health promotion, stigma reduction and other national initiatives.
- Funding for Queensland Primary Health Networks increased on average by 8 per cent from

$137.1 million in 2020-2021 to $148.7 million in 2021-22, with Northern Queensland receiving the largest funding increase (16 per cent).

- Of the PHN funding, services for young people (which includes Headspace, youth severe and early psychosis) received the most funding (34 per cent), followed by psychological therapies (20 per cent) and psychosocial support (16 per cent).
- There has been a substantial increase in funding to the primary care sector, particularly with MBS subsidised services for psychiatrists and allied health professionals since 2006.
- Expenditure for MBS subsidised mental health services in Queensland increased from $93 million in 2007-08 to $284 million in 2019-20[3].
- This has resulted in improved access for consumers and underscores the significant role primary healthcare plays in the mental health sector.
- At a national level, expenditure on mental health-specific Medicare items in major cities (across all provider types) far outweighs expenditure in regional and remote locations of Australia.
- $1.05 billion in major cities in 2019-20 compared with only $220 million in inner regional areas, $68 million in outer-regional areas, and $8 million in remote and very remote locations.
- Alcohol and other drug services are also commissioned through Primary Health Networks via the Australian Government Department of Health.

Non-government

- The state government funded a range of NGOs a total of $50.7 million (6.1 per cent of the total Queensland government contribution to the mental health budget) in 2019-20 to provide psychosocial support and specialist services tailored to specific vulnerable population groups, including, eating disorders, refugees, culturally and linguistically diverse, and young children aged 0-4 years.
- Funding to NGOs in Queensland in 2019-20 has fallen since 2016-17 (which was the record investment of $95.67 million) to $50.7 million in 2019-20. There has been an average annual reduction in expenditure of 13.6 per cent. This is in part due to some programs previously funded by the State government being folded into the NDIS.
- At 2019-20, Queensland's expenditure on NGOs was $9.87 per capita compared with a national average of $15.27 per capita. This is the second-lowest per capita expenditure in Australia (with Victoria spending the lowest at $9.03).
- In response to the impacts of the pandemic, the Queensland Government's Mental Health and Wellbeing Community Package also included non-recurrent $28 million for the broader non-government sector. Sectors included but not limited to mental health, alcohol and other drugs, Aboriginal and Torres Strait Islander health and so forth.
- In 2019-20 in Queensland, more than two-thirds (68 per cent) of alcohol and other drugs agencies receiving public funding were non-government treatment agencies.
- 50 per cent of the 194 non-government alcohol and other drugs treatment services were located in major cities, followed by outer regional (21 per cent) and inner regional (19 per cent) areas. Around 11 per cent of all government treatment agencies were located in remote and very remote areas.

[3] Australian Institute of Health and Welfare 2019, Mental Health Services in Australia.

- In the five years to 2019–20, the number of publicly funded alcohol and other drugs treatment services in Queensland steadily increased from 158 in 2015–16 to 194 in 2019–20.

Private health

- Expenditure on inpatient and outpatient mental health services through private hospitals was $583 million in 2019-20 (average annual per cent increase of 3.2 per cent).
- This growth reflects the greater awareness of insurance holders of the availability of mental health services through the private hospital sector.
- Benefits paid by private health insurance for in-hospital mental health care claims totalled $628 million (a 3.4 per cent increase on the previous year). In addition to this, a total of $31.8 million was made for claims related to psychological services.
- Private hospital insurance does not currently fund MBS services outside of hospitals. Despite evidence that many mental health services for high-prevalence conditions can be effectively provided in the community. There is interest from Private Health Insurers to explore community-based stepped care.
- There is an increasing number of people who do not have private health insurance cover and of those who do, many policies require significant co-payments.
- This intensifies the reliance on the public mental health system, which unlike the private sector, has its growth funding essentially capped (at 6.5 per cent).

What are the issues?

Funding allocation

Severe shortfalls

- Total expenditure on mental health services in Queensland has not grown commensurate with population growth.
- Based on the adjusted apportioning of State and Commonwealth contributions, the combined 2019-20 Commonwealth-State funding in Queensland ($393) was below the national average ($403) and the second lowest of the jurisdictions.
- Similarly, the Queensland Government contribution ($161) was the second lowest of all the States and Territories.
- Expenditure on mental health-related services represents 7.8 per cent of government health expenditure despite mental health and substance use disorders comprising the fourth largest contributor of total disease burden (12 per cent)[4].
- Despite substantial investment, the proportion of the population with mental ill-health is not decreasing. Indeed, the emergence of COVID-19 pandemic has exacerbated the many determinants of mental illness and epidemiological research has pointed to these determinants increasing the prevalence of common mental health disorders over the longer term[5].
- There are some significant shortfalls within the current service delivery system in Queensland that need to be addressed as a matter of priority. Current gaps in these areas are directly increasing the demand for acute mental health services.

[4] Australian Institute of Health and Welfare 2020, *Burden of disease*, viewed 14 February 2022, https://www.aihw.gov.au/reports/australias-health/burden-of-disease
[5] Daly, M & Sutin AR, Robinson E. 2020, 'Longitudinal changes in mental health and the covid-19 pandemic: evidence from the UK householdlongitudinal study', in *Psychol Med*, vol. 13, 1-10

- These gaps are predominantly in:
  - Residential treatment beds for adults as well as non-acute beds for older people. Queensland has a little over 50 per cent of the residential treatment beds needed to meet benchmark targets.
  - Community ambulatory mental health treatment for older people. Currently, Queensland has 20 per cent of the FTE required to meet benchmark targets.
  - The range of psychosocial supports in the community in line with strategic directions and to meet the needs of those people who are not eligible for the NDIS.
- Commonwealth programs which previously delivered psychosocial support have transitioned into the NDIS, leaving very little support for people with psychosocial disability outside the NDIS.
- Estimates from the NMHSPF suggest that 690,000 people with mental illness would have benefited from some psychosocial support in 2019-20.
- Among these are 290,000 people nationally with severe and persistent mental illness who are most in need of psychosocial support, while just 88,000 will access support upon full rollout of the NDIS by 2030[6].
- Approximately 75,000 people receive psychosocial support directly from other Australian, state and territory government-funded programs[7]. However, there is a significant gap in Australia's provision of psychosocial supports, particularly for those not receiving NDIS support.
- It is estimated that there are somewhere between 551,000 people with *significant mental illness* to 151,000 with *severe and persistent mental illness* who would benefit from psychosocial support, who are missing out[8].
- Community Mental Health Australia has estimated that an additional $610 million per year in Commonwealth Government funding is required to provide psychosocial support services to people with severe and persistent mental illness[9].
- Funding to non-government organisations rose from 2 per cent of total spending by states and territories to approximately 7.25 per cent in 2017-18.
- Contrast this with the New Zealand example, where the target for total HHS spending on psychosocial support is approximately 20-25 per cent, contributing to fewer presentations to emergency departments, fewer days in inpatient care, and reduced the rate of admission and readmission.

The 'missing middle'

- Currently, the mental health system consists of services predominantly aimed at individuals at the two ends of the continuum, that is, the mild to moderate and the severe. But the lack of clarity between Commonwealth and State responsibilities means that neither end can meet the diverse needs of the individuals accessing their services.
- There is a substantial cohort of people who are in the 'middle' - individuals whose needs aretoo complex or severe to be supported by primary or private health services alone, but not unwell

[6] Productivity Commission 2020, *Mental Health*, Report no. 95, Canberra
[7] Ibid
[8] Ibid
[9] Community Mental Health Australia 2021, Community Mental Health Australia 2021-22 Federal Pre-Budget Submission, viewed 9January 2022, https://treasury.gov.au/sites/default/files/2021-05/community_mental_health_australia.pdf

enough to meet criteria for entry into public mental health services.

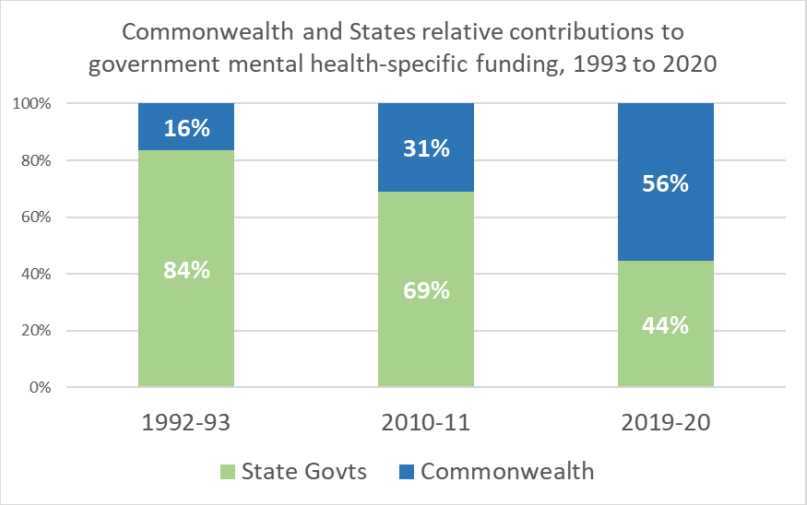
- Estimates of the quantum of this 'missing middle' are somewhere around 18 per cent of the population of people who are unwell.
- That is more than 150,000 people in Queensland who are not currently being serviced by either the public mental health or the primary care sectors. This estimate does not consider the fact that services across sectors are not accessed in mutual exclusivity and that consumers move across services as their needs change.
- Nonetheless, this estimate confirms what providers across sectors are increasingly recognising – that there is a cohort of people with mild to moderate severity of illness whose needs are not currently being met within the existing service system.
- Given the Commonwealth government's expanded role in funding services for individuals within the mild to moderate levels, considerable investment targeted to addressing the needs of this cohort and integrated with existing services at either ends of the spectrum is needed.

Funding administration

State-Commonwealth interface

- Commencing in the late 1990s, governments became increasingly aware of the major gap between the need for mental health care and the availability of services.
- The Commonwealth sought to fill the gap by strengthening primary care mental health services and developing population-level mental health promotion and prevention programs. Its role in funding mental health service delivery expanded substantially with the advent of the COAG National Action Plan on Mental Health 2006-2011.
- That plan marked the first time that a COAG-level agreement had been reached on mental health and was the largest government collective investment in new mental health.
- Some of the changes introduced by the Commonwealth were within its traditional domain.
- Most significantly, in 2006, psychologists and selected other non-medical professional groups were added to the MBS as providers of Medicare-subsidised mental health care through what became known as the Better Access program.
- In parallel, it also began funding and developing services previously the exclusive province of State and Territory governments. These included, for example, personal support and day programs targeted to those with severe mental illness. In later years (2011 onwards), new Commonwealth funding emerged for early psychosis centres, adult community mental health centres, residential centres for people with eating disorders and a range of psychosocial supports for those with disability arising from mental illness.
- This has exacerbated cost-shifting between governments, particularly in relation to the expanding role of the MBS in providing care to people discharged from hospital and others in the community.
- Historical growth in the relative contribution of the Commonwealth government to mental health at the national level is shown in Figure 2.
- From its low base of a 16 per cent contribution in 1992-93, the Commonwealth now (2019-20) accounts for 56 per cent of all government funding for mental health nationally.

Figure 2: Relative Commonwealth-State shares of mental health-specific funding, 1993 to 2020.



- Unsurprisingly, expanded Commonwealth funding is welcomed widely across the sector. But it has come at the price of increased fragmentation, duplication, and diminished accountability, particularly where that growth has ventured into traditional State-funded areas of service delivery.
- Mental health services in Queensland have substantial areas of responsibility that are shared or duplicated between the Commonwealth and State governments.
- As a result, the mental health system is hard to navigate, not only for clients but also for service providers. It is difficult for service providers to know who is funding what service, and in turn, very easy for governments to pass the responsibility on to a different level or part of the government.

Siloed and misaligned allocation

- Despite the interdependent responsibilities of the Commonwealth and State governments in the treatment of individuals, services are not *operating* in an interdependent way.
- The mental health service system is not adequately set up to respond to individuals moving back and forth between Commonwealth and State-funded services.
- Greater intergovernmental and cross-departmental arrangements and approaches are needed to ensure joint planning and coordination across levels of government and portfolios to better address the social and economic determinants of mental health and wellbeing.
- Sustained and significant investment in intervening early in the course of illness and early in the lifespan is vital and will require an investment methodology attuned to a broad-ranging variety of vulnerable population groups.
- Despite the evidence that demonstrates that substantial, and potentially the greatest, shifts and savings will come from promotion, prevention and early intervention strategies, there is a lack of priority, coordinated planning, and ad-hoc investment in Queensland and nationally.
- There are specific challenges in shifting the balance of resources towards mental health promotion and prevention, even when evidence about return on investment is strong.

- A significant issue is the lack of an equitable cross-agency funding model for prevention and promotion, and robust and meaningful outcome measures relative to the diverse range of environments that are implicated.
- Where action is taken it is frequently ad hoc and time limited, and largely in the form of mental illness literacy and promoting help-seeking. While these are important there is a lack of action that deliberately and effectively target the significant social and structural drivers of, and risk factors for, mental illness.
- Mental health promotion, prevention, and early intervention outcomes, by definition, are not expected to take effect in the short to medium term, providing a disincentive for investment. The upfront costs of effective upstream interventions often rest largely on universal systems such as early childhood, education, and communities; however, the benefits are substantially shared by downstream systems such as justice, corrections, police, and health.
- Diffuse responsibility for providing psychosocial support services has resulted in poorer consumer outcomes and challenges for many NGOs in delivering services. These include funding uncertainty in one source, which can result in the overall risk of not continuing service delivery, different reporting requirements and contract timeframes creating administrative burden, current funding arrangements failing to incentivise cooperation between providers, and short funding cycles limiting the effectiveness of services and hampering workforce attraction and retention.

Lack of connection between policy and funding

- Even though evidence-based strategic policy directions guide priority setting across the mental health sector, there is a palpable missing link and line of sight between policy directions, funding, and implementation.
- Many additional services and service models are being introduced into the system (which, although they support strategic policy directions) are allocated in a fragmented manner without consideration of the existing system landscape and how leverage could be applied to make the best use of resources. This issue goes beyond service providers merely collaborating. It is perpetuated by fundamental systemic barriers stemming from funding issues that stifle genuine integration efforts, let alone innovation.
- The objective of mental health system integration has been elusive for all reform efforts over the last three decades. Despite it being a prominent theme of all five National Mental Health Plans since the original in 1993, there has been a persistent failure to achieve integrated action between governments. Instead, the widening gap between policy rhetoric about governments working together and the practical reality on the ground has meant that commitments have not translated into effective collaborative action.
- If funding is to be optimally applied, ways to improve integration of services will be key to creating an efficient system. Integration must move beyond merely collaborating across sectors. It must involve co-funding, co-development, co-commissioning, and co-delivery of services emboldened by a shared purpose and agreed outcome measures.

Funding levers not applied optimally

- PHNs and public sector services are increasingly using the National Mental Health Service Planning Framework (NMHSPF) as a tool to support demand modelling and service planning.
- Implementation of the tool is at a developmental stage even though there is broad support for the tool to inform purchasing and commissioning.
- Ongoing tool development is required, and adjustments to the model to account for the differing needs of specific vulnerable populations are needed, particularly for rural and remote, Indigenous, and culturally and linguistically diverse communities.
- A robust monitoring system must also be established alongside the framework to evaluate what is delivered against what is funded.
- The Drug Policy Modelling Program has developed the Queensland Drug and Alcohol Services Planning Model (Q-DASPM) at the University of New South Wales (UNSW). It represents a part of the process for identifying service delivery needs for alcohol and other drug treatment services.
- There is a lack of broad visibility on how the Q-DASPM and the NMHSPF are being applied within the Queensland context.
- Mental health commissioning and contracting arrangements are hampered by siloed decision-making, short-term contracts that create staff insecurity and inconsistent reporting and data requirements.
- Payment structures (whether through ABF or PHN commissioning) do not currently incorporate mechanisms to incentivise service delivery in ways that support reform (both in terms of addressing service gaps and changing clinician practice).
- Whilst all sectors increasingly realise the benefits of joint planning and co-commissioning of services, achieving this is time-consuming, and not all players participate in joint planning with the same level of capacity to effectively engage in these processes.
- The complex and holistic needs of some vulnerable population cohorts present additional challenges as market availability is an issue for some specialist services and additional resourcing to enhance service development and planning capacity is required.
- Without joint funding mechanisms, the benefits of joint planning and commissioning cannot be fully realised because there is a lack of mutual benefit and where there is an uneven playing field – there will be a tendency towards cost-shifting.
- Issues in implementing funding also stem in part from the existing system of devolved governance in mental health whereby direct service providers operate at arm's length from system managers.
- Optimal service mix will differ across regions, and the risk with having rigid governance is that a uniform approach to implementation will not address the needs of vulnerable or disadvantaged populations.

Potential leverage points

Address structural barriers

- The sizeable proportion of Commonwealth contribution to mental health underscores the complex interrelationships and interdependencies that exist between governments. This

relationship ultimately impacts how services are accessed and delivered and the overall efficiency and quality of those services.

- Although additional funding is required, more funding will not necessarily address the structural problems existing in the system bedrock.
- Genuine reform of mental health services will need to address the Commonwealth-State interface if a more coordinated and cohesive service delivery system is to be achieved.
- The significant growth of Commonwealth mental health funding highlights how critical it is for policymakers to work together to achieve the best outcomes from their combined investments.
- Mental health is one of the most complex policy areas. Solutions to the challenges that affect mental health must include collaboration across portfolios to address the social, economic, health, occupational, cultural, and environmental factors involved in mental health and wellbeing.
- Given the role of National Cabinet Reform Committees, opportunities could be explored regarding the possibility of developing a cross-portfolio membership of a subcommittee to address mental health.

Explore alternative funding models

- The Productivity Commission recommended a new approach to funding mental health services involving transitioning to Regional Commissioning Authorities, where funds currently administered by PHNs and HHSs are pooled and commissioned.
- Consultation with Queensland stakeholders on this approach could be explored as to whether the current Queensland context is conducive to such a model.
- Consideration given to trialling and evaluating innovative fundings models in Queensland could be implemented to test whether large-scale reform is viable given the current service mix and local needs.
- Options to expand ABF funding to include community ambulatory mental health services could be further explored. Alternative funding models that can address specific areas of reform could be further investigated.
- For example, the Victorian Department of Health and Human Services currently uses options to fund community ambulatory mental health services on a fee-for-service payment model based on time spent treating individuals rather than an episode of care.
- Funding models must be underpinned by robust governance, monitoring, and evaluation focused on goals relevant to consumers and focused on achieving efficiency and quality of services – regardless of funding source.

Address urgent service gaps

- Additional new funding is required to address urgent service gaps across the mental health service delivery system.
- Rebalancing the overarching system requires urgent prioritisation within the following areas (but not limited to):
  - additional mental health ambulatory community services and mental health beds in line with benchmark targets,

  - considerable increase in funding for community-based clinical and non-clinical supports, that is commensurate to population need particularly for those individuals who are not eligible for NDIS,
  - considerable increase in alcohol and other drug funding across all service types, and
  - additional new funding to develop a new front door to mental health services through models that can better meet the holistic needs of the 'missing middle' in line with benchmark targets.
- Specific areas for prevention and early intervention priority action can be identified based on solid evidence, including investment and joint action in the early years, childhood, adolescence, and everyday life's 'big' environments, including families, schools, workplaces, and communities.

Submission to the

Inquiry into the opportunities to improve mental health outcomes for Queensland

Mental Health Select Committee

February 2022

Acknowledgements

We acknowledge Traditional Custodians of the lands and waters across Queensland, pay respect to Aboriginal and Torres Strait Islander Elders, past and present, and acknowledge the important role of Aboriginal and Torres Strait Islander people, their culture, and customs across Queensland.

We also acknowledge people living with mental health and alcohol and other drug problems, as well as those impacted by suicide, and their families, carers, and support people. We can all contribute to an inclusive and respectful society, where everyone is treated with dignity, focused on wellness and recovery, and leads flourishing lives.

\We acknowledge the professionalism and dedication of the broader mental health and alcohol and other drugs workforce and their concerted efforts to supporting the quality-of-life outcomes for all Queenslanders.

Contents

Key messages

- Mental health is more than the absence of mental disorders and is the foundation of flourishing and prosperous individuals, families, communities, and society. It supports our broader social and economic performance, long-term growth, and sustainability. Focusing on the mental health and wellbeing of Queenslanders represents a critical opportunity to improve outcomes for current and future generations.
- Numerous inquiries, reviews and reports have been conducted on the mental health system nationally and across jurisdictions over the past 30 years. Despite the considerable investment and efforts by both the Commonwealth and Queensland Governments, the current mental health system is not designed nor equipped to adequately respond to the growing needs of people with mental ill-health, psychological distress, problematic alcohol and other drugs use, and suicidality, their families, carers, and support people. The Productivity Commission (2020) conservatively estimated mental ill-health to cost the national economy $200-220 billion per year or between $550-600m per day.
- The current mental health service system primarily offers support at the two ends of the needs spectrum, and neither of these service components can meet the needs within their area of responsibility. A large and growing group have needs too 'complex' for support through primary care alone, but not 'severe' enough to meet the strict criteria for entry into specialist mental health services. This group of people is termed the 'missing middle', and the service gaps present a significant challenge. Adequate and appropriate resourcing at the non-acute middle level of community-based mental health and wellbeing could reduce demand for crisis care, stemming escalation to acuity, and alleviate pressure on more costly systems.
- It is estimated that the current alcohol and other drugs system meets 26-48 per cent of demand for alcohol and other drugs services. Queensland's current illicit drugs policy costs approximately $500 million per year to administer. As important as *how much* is spent is *where* it is spent. Approximately 60 per cent of funding goes to supply reduction, with the balance on treatment, prevention, and harm reduction. Diversion, for example, has the dual capacity to maintain community safety and divert people from a criminal trajectory to a health response that better addresses the underlying issues contributing to problematic alcohol and other drugs use.
- Consumers report a complex patchwork of services that reflect historical funding models, have little continuity between providers, settings and types of treatment, care, and support; and poorly match consumer needs[12]. A better-integrated system would eliminate service gaps and inconsistencies between and within public, private and non-government services. A new, community-based mental health infrastructure should become the broad front door for all mental health needs. Delivered through diverse modes, it should co-locate and integrate standardised service offerings across public, private and NGO providers, including primary healthcare.
- To genuinely improve the social and economic participation of people living with mental illness, a wide-angle view is required, well beyond a focus on clinical outcomes. This includes satisfying four key areas: timely and quality access to clinical services, psychosocial support, access to affordable housing, and continuation and return to education and employment. Priority must also be given to improving population mental health and wellbeing, reducing vulnerability among at-risk groups, and early intervention in the onset of mental health challenges. There has been minimal investment in prevention and early intervention over the years despite the weight of evidence that clearly shows a strong return on investment.
- Promoting positive mental health and wellbeing is a fundamental responsibility shared across communities, systems and sectors, industries, and governments. Improving mental health and wellbeing outcomes requires action by systems and services within and beyond the healthcare sector. A compassionate, person-centred, strategically aligned, integrated, and coordinated mental health and wellbeing system supported by whole-of-government and cross-sector effort is critical to delivering the outcomes that matter at the individual, population, and system levels.

Introduction

- The Queensland Mental Health Commission (the Commission) welcomes the Mental Health Select Committee (the Committee) Inquiry into opportunities to improve mental health outcomes for Queenslanders (the Inquiry). This submission responds to the Terms of Reference governing the scope of the Inquiry.
- The Commission appreciates that this Inquiry will take an inclusive and overall social and economic view of Queenslanders' mental health and wellbeing. This submission will reference the whole-of-system, whole-of-population, and whole-of-person impacts resulting from the apparent gaps in the overall architecture of the mental health and wellbeing landscape.
- It must be noted that mental health and wellbeing stretch beyond public mental health and the broader health system.
- Promoting positive mental health and wellbeing is a fundamental responsibility shared across communities, systems and sectors, industries, and governments—and improving outcomes requires the contribution of systems and services within and beyond the healthcare sector.
- Queensland Government agencies contribute to, and make significant investments in services and programs to prevent and reduce the impact of mental ill-health, problematic alcohol and other drugs use, and suicide. However, no one agency, level of government, group, or community can improve the mental health and wellbeing of Queenslanders alone.
- Understanding the overarching context, systems, and settings relevant to, and intersections with, the broader mental health landscape is critical to understanding the functioning of the mental health system, and the key issues and gaps in our current approach, both within and beyond the health system.
- The reform ambition is more than improving parts of the mental health system and requires more than system adaptation[3]. Therefore, consideration of the relationships and intersectionality of reforms and systems within and beyond the healthcare system is needed.
- Understanding the broader context is critical to understanding how to optimise our current approach and the next steps to move towards an integrated, person-centred, community-based, future-oriented, and ultimately compassionate mental health and wellbeing system, commensurate to population needs.
- This submission considers the clinical and non-clinical aspects of supporting mental health and wellbeing, through a whole-of-life, population-based approach across the continuum of care.
- This includes strengthened community-based approaches to support social and economic participation. It looks beyond the health system to consider how, for example, the education, employment, social services, housing, and justice systems can support improved mental health and wellbeing and enhanced social and economic outcomes for Queenslanders.
- The submission also identifies groups not adequately or appropriately served through the current system, critical leverage points for systemic change, and areas of excellence for consolidation.
- Finally, it proposes key, mutually reinforcing recommendations or areas for further consideration.

Overview of the Queensland Mental Health Commission

- The Commission is an independent statutory agency established under the *Queensland Mental Health Commission Act 2013* (the Act) to drive ongoing reform towards a more integrated, evidence-based, recovery-oriented mental health and substance misuse system.
- Under the Act, the Commission focuses on systemic mental health and problematic substance use issues. In addition, the Commission takes account of the issues affecting people who are vulnerable to or at significant risk of developing mental health problems; and recognises the

importance of custom and culture when providing treatment, care, and support to Aboriginal and Torres Strait Islander peoples.

- The Commission's main functions are to:
    1. develop a whole-of-government strategic plan to guide innovation, integration, and coordination; and monitor and report on implementation to the Minister for Health
    2. monitor, review, and report on issues affecting the mental health and alcohol and other drugs system, the broader community, and consumers, their families, and carers
    3. facilitate and promote mental health awareness, prevention, and early intervention, and
    4. foster and support collaborative, participative, representative, and accountable partnerships, and state-wide mechanisms.

- The Commission promotes policies and practices aligned to the vision of the *Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023* (*Shifting minds*) and its sub-plan, *Every life: The Queensland Suicide Prevention Plan 2019-2029* (*Every life*), for "a fair and inclusive Queensland, where all people can achieve positive mental health and wellbeing and live their lives with meaning and purpose".
    - *Shifting minds* sets the strategic direction for a whole-of-government, whole-of-community, and whole-of person approach to improving the mental health and wellbeing of all Queenslanders. It is a five-year plan that represents a longer-term outlook. *Shifting minds* establishes three areas for strategic focus:
        - ***Better lives*** *through person-centred and integrated services*
        - ***Invest to save*** *through improved population mental health and wellbeing as well as intervening early, in life, in vulnerability and in illness and episode, and*
        - ***Whole-of-system improvement*** *through a balanced approach and collective action.*
    - *Every life* is a whole-of-government plan for suicide prevention in Queensland, with renewed drive and urgency to reduce suicide. *Every life* recognises suicide is preventable and emphasises the vital importance of working together to reduce suicide. It acknowledges that effective suicide prevention requires responses beyond health services and must incorporate the voices of people with lived experience. Aligned with national and international best practices, evidence, and innovation, *Every life* identifies four action areas:
        - ***Building resilience*** *by improving mental health and wellbeing in our people and communities*
        - ***Reducing vulnerability*** *by strengthening support to vulnerable populations and people*
        - ***Enhancing responsiveness*** *to suicidality, including enhanced options for care, and*
        - ***Working together*** *to achieve more through coordinated approaches and improved use of data and evidence.*

- The Commission has led a renewed approach to alcohol and other drugs in Queensland, which is currently pending Queensland Government consideration. It is based on extensive cross sectoral consultation and contemporary evidence. This approach seeks to prevent and reduce the impact of alcohol and other drugs on the health and wellbeing of Queenslanders. It supports the Queensland Government strategic direction outlined in *Shifting minds* and is aligned with the National Drug Strategy and sub-strategies. Priority actions under *Shifting minds* which seek to support the wellbeing of Queenslanders include:
    a. system-wide integration
    b. multi-agency responses to meet the needs of individuals and groups with complex needs

c. drug policy reform
d. alcohol harm minimisation
e. increasing alcohol and other drugs prevention and early intervention
f. growth and development across the continuum of service responses for problematic alcohol and other drugs drug use
g. workforce development, and
h. addressing stigma and alcohol and other drugs literacy.

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

Overview of an evolving landscape

- For over 30 years, the broader mental health landscape has undergone significant review and reform of mental health treatment, care, and support.
- Each review has undertaken a deep and comprehensive analysis of the systemic, structural, operational, and other factors that contribute to inefficiency and ineffective responses, as well as the urgent shifts and priorities required to improve responses. Such reform has contributed to and achieved many positive, long-term, and sustainable outcomes for people with lived experience and their families, carers, and support people. Examples include:
    - the shift away from large, long-stay institution-based psychiatric hospitals and the growth of community-based services, including the co-location of small inpatient units within general hospitals
    - evolving models of community care
    - evolution of the consumer and carer movement
    - strengthening of human rights
    - innovations in clinical treatments and non-clinical interventions
    - embedding recovery-based and trauma-informed approaches in service provision
    - workforce diversification, and growth of the clinical and non-clinical workforces
    - evolution of mental health governance mechanisms, service accreditation standards, advocacy, and appeals mechanisms, and
    - advancement of digital mental health services within the broader landscape.
- Numerous national and jurisdictional policies, plans and strategies have guided efforts to improve outcomes and deliver a quality mental health system[4]. However, the ongoing challenge has been implementing enduring change[5].
- Despite the concerted effort and growing investment, the prevalence of mental health conditions has not fallen, the burden of disease remains high, and there have been no sustained reductions in rates of suicide[6].
- Mental health remains under-resourced relative to other areas of health, and funding is disproportionate to the significant and growing burden of disease that it represents.
- The system architecture is complex and characterised by fragmentation, with limited integration within and across other areas of essential non-mental health service provision, ill-defined pathways between levels of care and services, duplication, and siloed approaches within and beyond the health system. The system is structured to rely on late, crisis, and acute responses often through first responders, emergency department presentations and acute inpatient care, but also criminal justice, homelessness, and welfare support.
- Access remains inequitable, and the undersupply of community-based mental healthcare has resulted in many people being unable to access treatment, care, and support at the right time, where it will benefit most. There is a significant gap between what community-based public mental health services are funded to provide, and estimated demand. This has resulted in many

people experiencing increasing distress and disruption to their lives, waiting extensive periods before care is available, or becoming increasingly unwell before able to access a service.

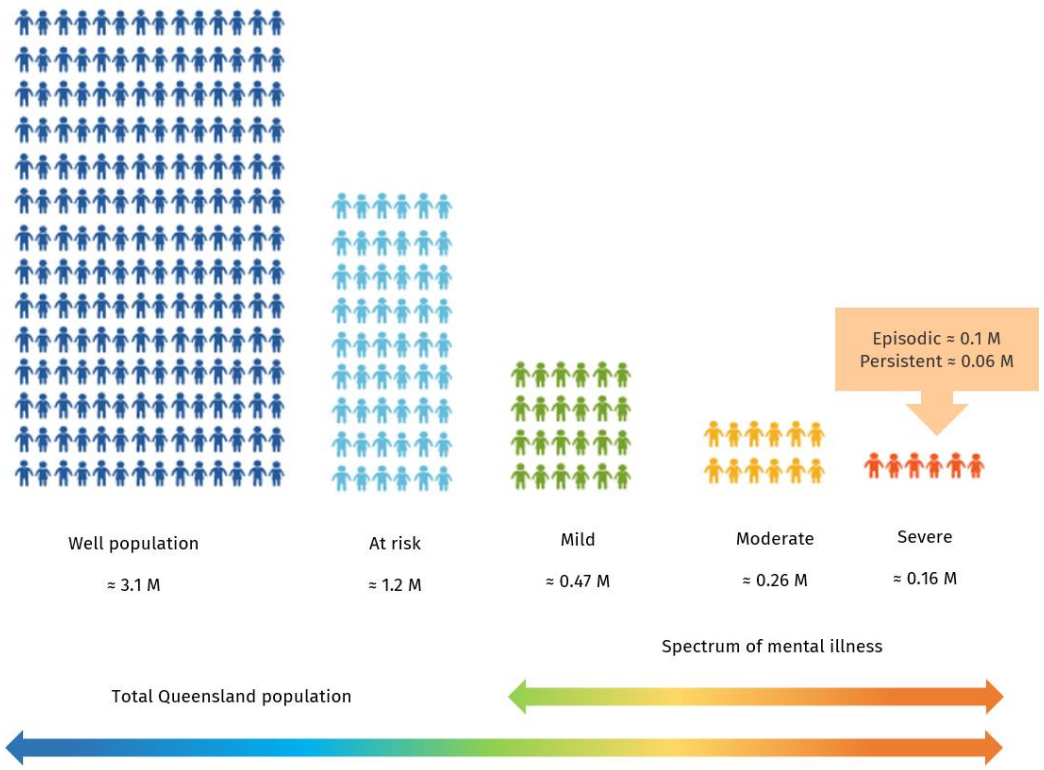
- There is a large and growing group, 'the missing middle', whose needs are considered too complex, severe, and enduring to be adequately supported through primary healthcare, but not severe enough to meet the threshold eligibility requirements for specialist mental health services. This imbalance has further contributed to an overreliance on medication as the main, or sometimes the only, form of treatment, inconsistent with recovery-oriented practice[7].
- Despite the concerted effort and increased investment, the system has become crisis-driven, and self-perpetuating, requiring sustained and increased investment to respond to the growing demand for late and acute interventions. Simply put, the system has become overwhelmed and cannot keep up with the demand for treatment, care and support, and the emergency department has become the entry point to mental healthcare by default and necessity.
- Notwithstanding the significant research and innovation demonstrating the clinical and cost-effectiveness of clinical, pharmacological, and psychosocial interventions to prevent and treat common mental disorders (CMDs), at scale delivery and translation into real-world improvements have been slow[8]. Ongoing efforts to improve the effectiveness of treatment and the availability and quality of support and services is essential. However, recovery is best supported by holistic and comprehensive approaches that consider whole-of-person needs.
- There are many proven and efficient ways to improve the present situation for better outcomes for individual, services, and the system. Through over 30 years of review and reform, there is solid and compelling evidence that supports rebalancing the system upstream to enable:
    - prevention and early intervention approaches across the life-course and in key settings. Such initiatives can play a critical role in achieving long-term, sustainable, quality-of-life outcomes including improved social and economic participation
    - clinical and non-clinical early intervention and support services that provide responsive care and support to populations at greater risk of mental ill-health, particularly related to the experience of social inequities, and
    - mental health and wellbeing care beyond the mental health system, and indeed the public health system. Cross-sector, cross-portfolio approaches with other systems and sectors are required to support the mental health and wellbeing of all Queenslanders.
- Mental health promotion, prevention and early intervention represent the best, most effective, and cost-efficient tools to prevent and reduce the impacts of mental ill-health, problematic alcohol and other drugs use, and suicide on individuals, communities, governments, and the broader economy.
- Focusing our resources upstream and in community-based approaches-through prevention, early support, clinical and psychosocial interventions, and community-based approaches makes economic and moral sense and will enable Queenslanders to live flourishing lives of their choosing[9].

Section 1: the case for major reform

1.1 Prevalence of mental ill-health

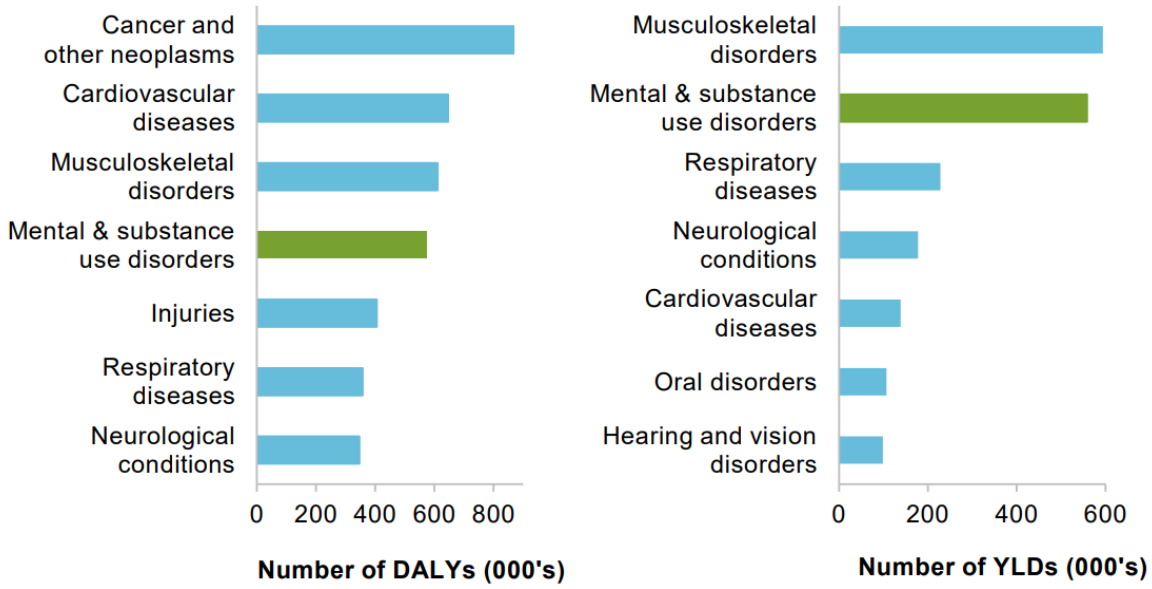
- Mental ill-health is common, affecting all Queenslanders directly or indirectly through families, carers, loved ones, friends, colleagues, peers, and the broader community. Appendix one provides the diverse nature of the Queensland community.
- The prevalence of mental illness is relatively similar across Australia, and almost one in two Australians will experience a mental illness in their lifetime[10].
- According to the *Fifth National Mental Health and Suicide Prevention Plan* (the Fifth Plan), at any point in time, the Australian population can be categorised into three groups, according to their mental health status and needs (**Figure 1**):
    - **Well population***:* approximately 60 per cent of Australians were in this category in the last twelve months. Efforts to keep people well and support their return to wellness through mental health promotion, prevention and early intervention can assist in maintaining and ultimately expanding this group over time[11].
    - **At-risk populations***:* 23 per cent of Australians were at risk of experiencing an episode of mental illness because they had symptoms over the last twelve months, had a prior mental illness or were exposed to another risk factor(s). Supporting people experiencing early symptoms or early stages of vulnerability may require self-help resources and low-intensity interventions.
    - **Populations living with mental ill-health***:* an estimated 17 per cent of Australians experienced mental ill-health over the last twelve months, with their condition being mild (9 per cent), moderate (5 per cent) or severe (3 per cent). It is estimated that approximately one-third of people living with severe mental illness have persistent or complex needs that may require ongoing services to support residual disability[12].

Figure 1: Distribution of mental health across the Queensland population[13]



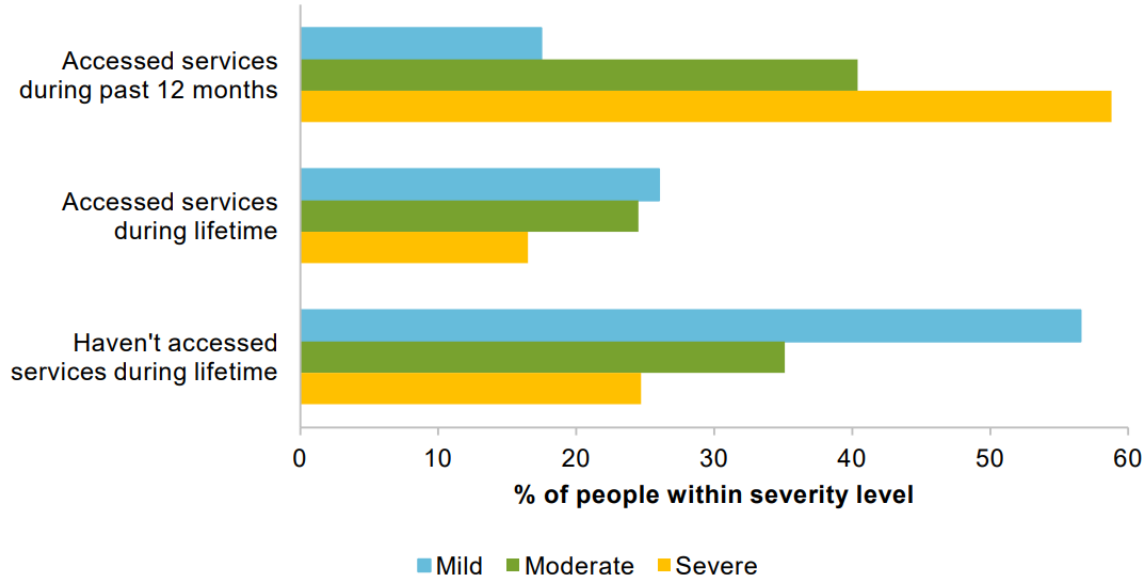
- Treatment, care, and support for people living with mild mental health conditions include a mix of self-help resources, including digital mental health interventions and low-intensity face-to-face services provided through primary care or community-based settings[14].
- Supporting people with moderate mental health conditions can require more specialist support, including psychosocial support services and specialist mental healthcare. This includes face-to-face clinical services provided through primary care and more specialist psychiatric support, where and if required. Other options that may assist people living with moderate mental health conditions include self-help resources, clinician-supported digital mental health services and other forms of low-intensity support[15].
- People living with severe and complex mental ill-health can require a clinical care response through a combination of primary care, psychiatrists, mental health nurses and allied health professionals. Responses may include inpatient treatment, pharmacotherapy, psychosocial support, and potentially coordinated multi-agency services.
- People who have experienced severe and complex mental ill-health in the past 12 months are more likely to access mental health services than people with mild to moderate mental health conditions. However, a substantial proportion of individuals with severe and complex mental ill-health do not access treatment.
- Mental health and substance use disorders represent the second-highest proportion of years lived with disability in Australia and comprises 12 per cent of the total health loss in Australia, behind cancer, cardiovascular diseases, and musculoskeletal conditions (**Figure 2**).

Figure 2: Burden of disability[16]



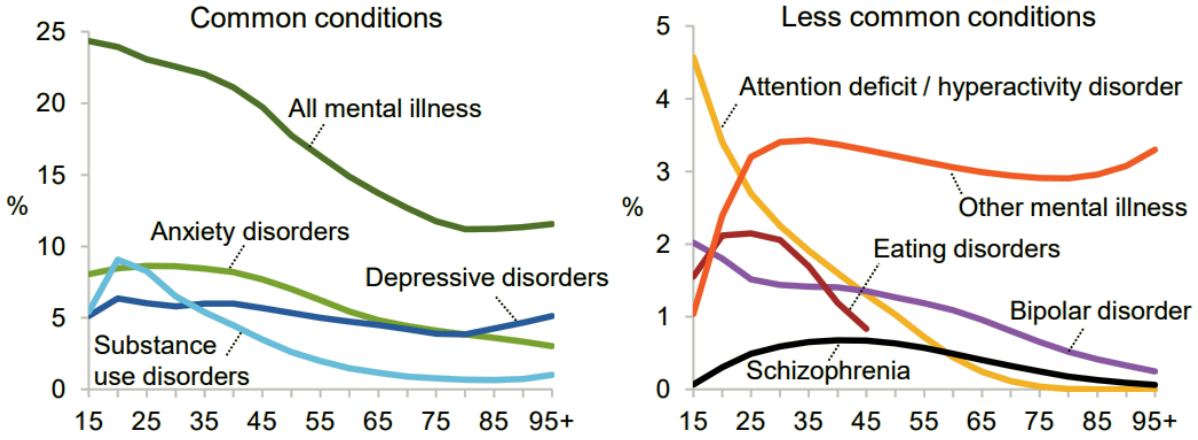
- Despite the prevalence of mental ill-health in Australia, government expenditure is primarily concentrated on providing acute mental health services. Access to timely, quality, and appropriate treatment, care, and support where it will benefit most remains a significant issue.
- **Figure 3** provides an overview of mental health service use by severity for adults aged 16-85 years in 2007[17].

Figure 3: Mental health service use, by levels of severity[18]



- Mental ill-health often starts early in life and persists across the life span (**Figure 4**), with significant onset during adolescence and young adulthood. In any given year, 1 in 7 children and adolescents will experience a mental disorder, with an estimated 50 per cent of adult mental illness beginning before the age of 14 years[19].

Figure 4: Prevalence of mental disorders by age[20]



- The perinatal period is another often-overlooked life stage for mental health challenges.
- Perinatal mental health describes the mental health and emotional wellbeing of parents from conception until two years after the end of pregnancy. For most families, this is a time of excitement and joy. However, adjusting to pregnancy and parenthood can be stressful.
- 'Perinatal mental illness' covers a range of emotional and mental health disorders, from mild and transient to severe and disabling. These can occur at any time during or after pregnancy, including after the termination of a pregnancy.
- The commonly experienced perinatal mental health disorders are anxiety, depression, or a combination of both. Other more serious illnesses such as postpartum psychosis or bipolar disorder can also occur.
- One in five women will experience anxiety and/or depression in the perinatal period, and one in ten men will experience anxiety or depression in the perinatal period. Based on birthing rates in

Queensland in 2020, 11,746 women experienced anxiety or depression in the perinatal period. This is a significant number of women and their families—all of whom will require additional support through primary, targeted and indicated mental health services.

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

1.2 Prevalence of mental ill-health and physical comorbidities

- On average, people living with severe mental illness die approximately 10 to 15 years earlier than the general population, often due to comorbidity issues[21].
- The correlation between mental ill-health and physical health comorbidities is bi-directional, shares common risk factors and—if left unaddressed—can further lead to poor physical, social, and economic outcomes.
- Negative outcomes include higher psychological distress, greater socioeconomic disadvantage, decreased ability to function, work or carry out daily duties, and reduced workforce participation[22].
- National and international evidence[23] indicates that four out of five people living with mental illness have coexisting physical health issues. It must be noted that common comorbidities are not just limited to physical health issues; there is a higher prevalence of intellectual and physical disabilities in people living with mental ill-health.
- When compared to the general population, people living with mental ill-health are:
    - two times more likely to have cardiovascular disease, respiratory disease, metabolic syndrome, diabetes, and osteoporosis
    - 50 per cent more likely to have cancer
    - six times more likely to have dental problems, and
    - comprise around one-third of all avoidable deaths[24].
- The relationship between physical and mental ill-health further increases healthcare use and costs. For example, in a submission to the Productivity Commission Inquiry into Mental Health (2020)[25], people living with comorbid depression and physical health conditions incurred increased care costs of between 33-169 per cent, excluding the direct costs of mental healthcare.
- However, despite the comprehensive and compelling evidence and given the significant gap in life expectancy, people living with comorbid physical and mental health issues are 50 per cent less likely to receive treatment, care, and support for their physical health needs than people living with a physical health condition alone[26].

1.3 Prevalence of alcohol and other drugs use

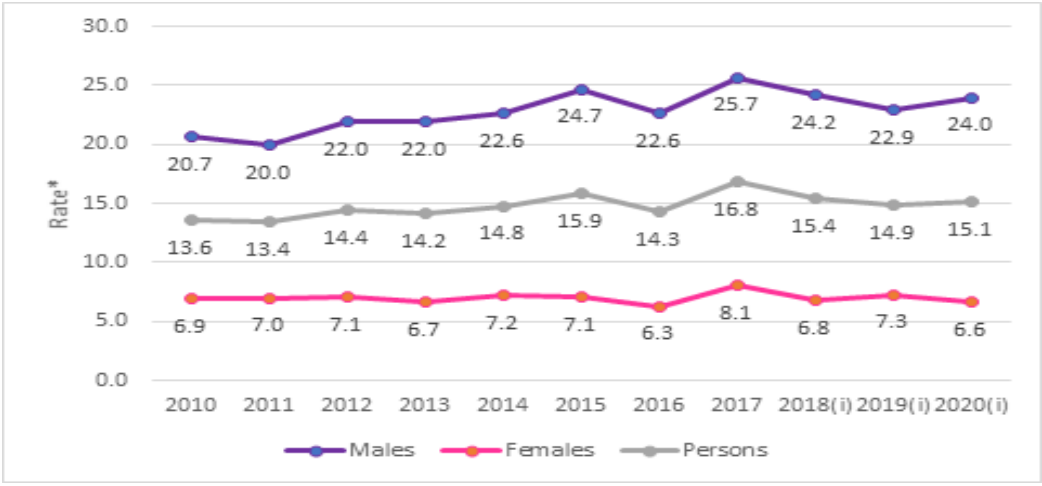
- Alcohol and other drugs use occur across a continuum, from occasional use to dependence, and harmful use can arise at any point, impacting individuals, families, and communities. Alcohol and other drugs use can be part of a complex set of co-occurring health and social problems.
- The *Australian drug harms study* ranks alcohol as the drug that causes the most significant harm to self and others, followed by crystal methamphetamine and heroin[27]. Alcohol use is one of the leading causes of preventable injury and early death in Queensland and is a leading contributor to the burden of disease. Approximately one in five Queenslanders (890,000) exceed lifetime risky drinking[28]. In 2019, 17.2 per cent of Queenslanders engaged in risky drinking, and 28.7 per cent engaged in single occasion risky drinking at least monthly in Queensland[29].
- In 2019, it was estimated that approximately 20 per cent of Queenslanders recently used an illicit drug; however, there has been a six per cent reduction in illicit drug use nationally since 2001[30].

- There is a complex interrelationship between mental illness and alcohol and other drugs use. A person may use substances to assist in managing mental illness symptoms, or substance use can trigger symptoms of mental illness. Determining whether mental illness preceded substance use or vice versa is difficult.
- The 2019 National Drug Strategy Household Survey showed:
    - people with mental health conditions or high or very high levels of psychological distress are more likely to drink alcohol at risky levels than people without these conditions
    - people with mental health conditions or high psychological distress are twice as likely to smoke tobacco compared to people without mental health conditions
    - people who reported high or very high levels of psychological distress were at least twice as likely to report current illicit drug use as those with low psychological distress, and
    - Aboriginal and Torres Strait Islander people comprised approximately 17 per cent of alcohol and other drugs treatment services clients aged ten years and over (2019-2020).
- The *2021 Illicit Drug Reporting System* estimated that 47 per cent of people who use drugs self-reported experience a mental health problem in the previous six months, consistent with results from 2020 (47 per cent)[31].
- Other forms of support may include housing, domestic and family violence, employment, child safety, legal concerns, or treatment for other health issues such as mental health concerns, and chronic illnesses.
- Treatment services need to collaborate and coordinate with other care systems as attending to overall health, wellbeing, and cultural and social needs enable treatment to be most effective[32].
- Despite the recent investment, the alcohol and other system are currently only meeting an estimated 26 to 48 per cent of service demand[33].

1.4 Prevalence of suicide and suicidality

- Queensland consistently records suicide rates above the national average and has the third-highest rate of suicide among all states and territories, behind the Northern Territory and Tasmania. The Queensland Suicide Register (QSR) shows that while the trend in numbers and rates of deaths by suicide in Queensland has increased since 2011, they have remained relatively stable following a peak in 2017 (**Figure 5)**.
- Suicide remains the leading cause of death for Australians aged 15–44 years, with regional communities reporting a 54 per cent higher rate of suicide than capital cities[34]. Suicide rates tend to increase with remoteness, with suicide rates in very remote regions reported to be almost twice that of the national average[35].

Figure 5: Age-standardised death rate per 1000,00 estimated resident population[*#]

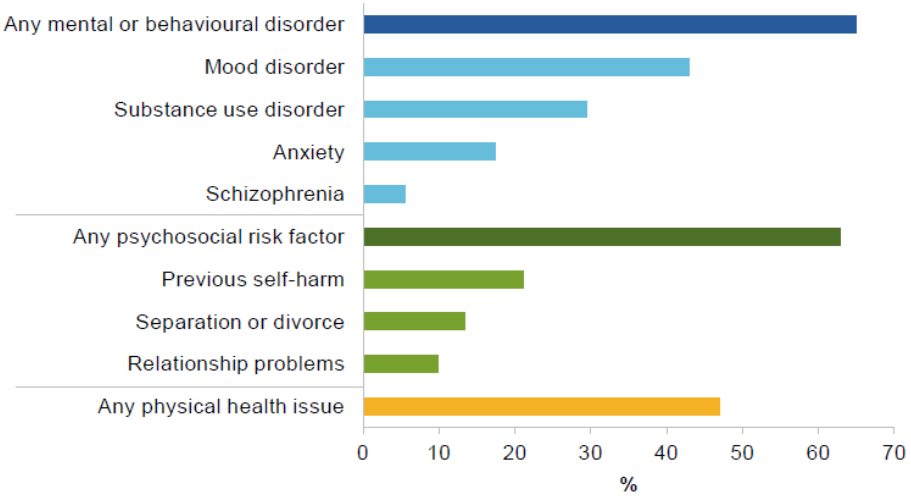


* Age-standardised death rate per 1000,00 estimated resident population as of 30 June (mid-year) (i) interim Queensland Suicide Register data 2018-2020.

Interim Queensland Suicide Register data 2018-2020.

- Suicide data shows that on average, a person who dies by suicide loses almost 43 years of life expectancy[36]
    - In 2013-14, self-harm and suicidal ideation were more commonly reported for young females aged 12-17 years. However, three out of four deaths by suicide are male37.
    - In 2015, approximately 25 per cent of people who died by suspected suicide had contact with a Queensland Health service within the seven days before their death38.
    - Further, research has identified that up to 20 per cent of people who died by suicide saw their general practitioner within one week before their death[39].
    - Aboriginal and Torres Strait Islander people are twice as likely as non-Indigenous people to be hospitalised due to mental illness and are twice as likely to die by suicide. Aboriginal and Torres Strait Islander youth (up to 24 years old) are up to 14 times more likely to die by suicide than other Australian youth[40]. For Aboriginal and Torres Strait Islander people, the median age of death by suicide is approximately 29.5 years, compared to 45.4 years for non-Indigenous Australians[41].
    - Young LGBTIQ+ people are at particular risk, including same sex attracted young people who are six times as likely to have attempted suicide[42] Almost half of young trans people had attempted suicide, and 80 per cent have self-harmed[43].
- It is estimated that between 15-25 per cent of people who attempt suicide will re-attempt, with the risk is significantly higher during the first three months following hospital discharge[44].
- While mental disorders are known to increase the risk of chronic disease and premature death from suicide[45], not all people who attempt or die by suicide have a mental illness. Almost two-thirds of people who die by suicide were experiencing a psychosocial risk factor—for example, a history of self-harm, separation, divorce, or relationship challenges[46]. **Figure 6** provides an overview of the proportion of suicide deaths associated with selected risk factors.

Figure 6: Proportion of suicide deaths associated with selected risk factors[47]



1.5 Impact of large-scale disruptions

- The COVID-19 pandemic continues to have broad, variable, and changing effects on the mental health and wellbeing of Queenslanders, with insights continuing to be gained on the ongoing impacts. However, there has been a deterioration in mental health at the population level[48].
- Globally, it is suggested that the impact of COVID-19 on the prevalence and burden of major depressive disorder (MDD) and anxiety were substantial, particularly among females and younger populations[49].
- Between mid-March to mid-April 2020, twice as many surveyed adults reported feelings associated with anxiety, predominantly associated with anxiety and experiences of feeling fidgety. Surveyed Australians reported increased levels of psychological distress, particularly associated with COVID-19[50]. According to the *first insights from the National Study of Mental Health and Wellbeing, 2020-21*[51], in 2021, 15 per cent of Australians aged 16-85 years experienced high or very high levels of psychological distress, with women (19 per cent) more likely to experience high or very high levels of psychological distress than men (12 per cent).
- In the early stages of the pandemic, agencies such as Beyond Blue, Headspace, Lifeline and Kids Helpline reported a 30-60 per cent increase in demand for phone and online support. In 2021, Lifeline reported the highest volume of calls for support in the organisation's 58-year history[52]. ADIS, a 24/7 alcohol and other drugs Queensland Health phone-based service, reported a 15 per cent increase in calls seeking assistance across Queensland during COVID-19.
- Over 2020-21, existing barriers to mental health treatment, care and support were exacerbated, including:
    - access and navigation barriers, including cost, waitlists, and lack of service options
    - societal barriers, for example, stigma and social inequity, and
    - disparities in the mental health system result in people falling through the gaps, unable to access timely, appropriate, and quality treatment, care, and support when and where they need it most[53].
- The connection between social and economic circumstances, mental health and wellbeing, and vulnerability to mental health challenges and illness continue to be emphasised. The pandemic has shown how uncertainty and intense, prolonged stressors such as physical safety risks, economic hardship, insecure housing, disruption to employment or education, reduced mobility, and social isolation can affect mental health and wellbeing.
- The COVID-19 pandemic followed a period of unprecedented environmental crisis, with many parts of Australia suffering from a destructive bushfire season. In Queensland, natural disasters including droughts, floods and fires have spanned several years. Individuals, families and

communities continue to experience the ramifications of such disasters on their lives and livelihoods and face additional stressors through the immediate and long-term implications of the pandemic.

- Despite this, there are many examples of individual strength and community resilience. This included the rapid mobilisation of a “care army” to support the health, safety and wellbeing of vulnerable community members.
- The past few years have proven significant in human, social, and economic reform, with mental health central to all three reform agendas. For example, the pandemic resulted in the rapid mobilisation of support within and beyond the mental health, alcohol and other drugs, suicide prevention and related sectors, driving new ways of working together. This is particularly evident through a shift in service delivery models to emphasise community-based support and telehealth and online support integration.
- While it must be noted that such progress has been ongoing, the experience of the COVID-19 pandemic further propelled diverse systems and sectors to:
    - source additional funding and enable creativity and flexibility in the way we conceive, commission, and deliver services, commensurate to population need
    - increase coordination, collaboration, and cooperation across and beyond the mental health and alcohol and other drugs sectors and this included re-deploying and pooling staff into organisational areas of greatest need
    - overcome barriers to information and data sharing to facilitate informed, real-time decision making
    - prioritise the provision of appropriate, quality and timely support to people in situ
    - continue face-to-face service delivery where possible, as well as leveraging technology to modify service delivery and enable access to treatment, care and support, and
    - consider the importance and need to rebalance the system within and beyond the health sector[54].
- Moving forward, our challenge is to consolidate and build on the many gains, learnings and innovations from the pandemic and other adverse events to benefit longer-term mental health and wellbeing reform.

Section 2: the social and economic impacts of mental health and wellbeing

2.1 Social and economic benefits of prioritising mental health and wellbeing of Queenslanders

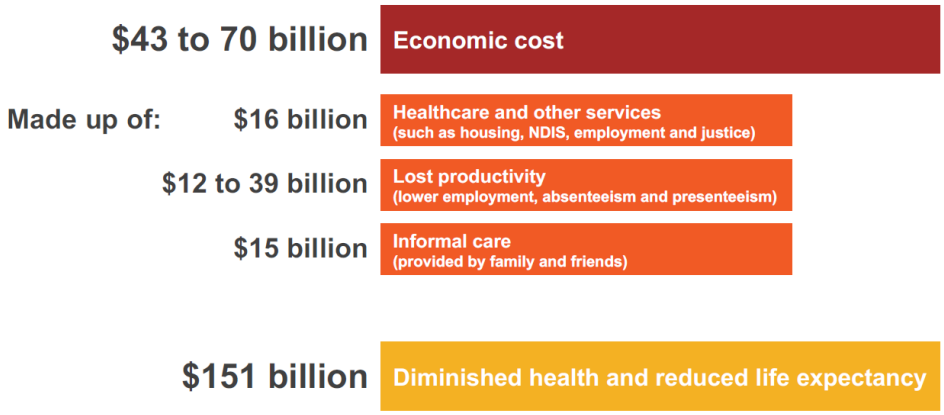
- The World Health Organisation acknowledges that mental health is more than just the absence of mental disorders or disabilities.
- Research demonstrates that strengthening mental health and wellbeing decreases the risk of future mental illness and protects against other health conditions (such as dementia). The *National Preventive Health Strategy 2021-2030* has recognised the strong connection between mental and physical health, and the Strategy includes actions to promote and protect mental health[55].
- Mental disorders can be prevented, and it must be noted that effective prevention strategies already exist[56].

  "*We know what factors promote mental health and what factors can trigger mental illness. We also know what makes communities healthy—the factors that contribute to a positive child-rearing environment; the impact of alcohol, physical, emotional and sexual abuse on the future of young people; and the counterproductive impact of stress in the workplace. The question now is not one of what we ought to do, but whether we will do it, and when*"[57].
- Importantly, prevention saves money. There is considerable and growing evidence of the escalating costs associated with the current late intervention approach and equally significant evidence supporting the cost-effectiveness of mental health promotion and prevention initiatives.
- A report into the economic benefits of prevention prepared for the National Mental Health Commission (2016)[58] assessed ten interventions to prevent depression and anxiety and found nine had a positive return on investment, ranging from $1.05 to $3.06 for each dollar invested. Other research confirms that many initiatives to prevent the onset of mental disorders are cost-effective and save money[59].
- The substantial individual, social, and economic benefits of investing in reforms that prioritise positive mental health and wellbeing are clear.
- It is an enabler of social participation and productivity, positive community engagement and cohesion, and is critical to long-term growth and broader economic productivity, sustainability, and development[60].
- Countries including Finland, Iceland, New Zealand, Scotland, Wales[61], and the ACT Government[62] have prioritised the creation of "wellbeing economies". This reform agenda undertakes a holistic, collaborative and iterative approach to policy-based interventions that influence economic behaviours in pursuit of societal goals[63] and address societal needs[64].
- Focusing on the mental health and wellbeing of Queenslanders represents a critical opportunity to improve outcomes across all life domains and across current and future generations.
- This includes reducing pressure and demand for costly treatments and late interventions across a range of human services such as child protection and youth justice, homelessness services, corrections and emergency services; as well as community-based supports and tertiary and specialist health and mental services, including hospital inpatient and emergency department care and emergency service responses.

2.2 Social and economic impacts of mental ill-health

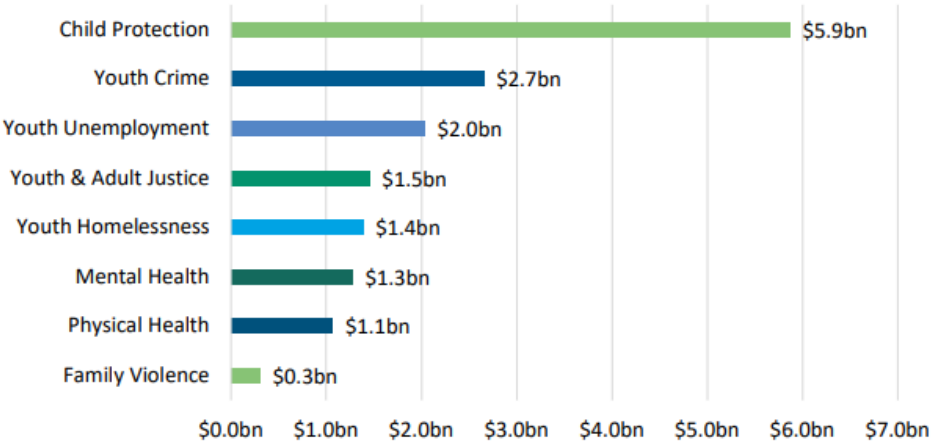
- The Productivity Commission (2020) conservatively estimated that mental ill-health cost the national economy $200-220 billion per year or between $550-600m per day[65](**Figure 7**). Based on Queensland's population, the cost to Queensland can be estimated at 20 per cent of these costs, with widespread impacts for individuals, communities, systems, sectors and the economy.

Figure 7: Annual cost of mental ill-health and suicide[66]



- The cost to the government of late intervention in Australia is $15.2 billion per year, equating to $607 for every Australian, or $1,912 per child and young person. Late intervention costs include the cost of specialist mental health services, out-of-home care, homelessness, youth unemployment, police, courts, and general health costs of youth crime[67] (**Figure 8**).

Figure 8: Annual cost of late interventions in Australia by issue (2018-19, prices, $BN)[68]



- Perinatal mental illness has been identified to cost $877 million in the first year, with an additional estimated lifetime cost of $5.2 billion. This lifetime cost is attributable to the increased risk of depression, anxiety, and ADHD in the children of parents with perinatal anxiety and depression, affecting wellbeing, productivity, and health system use[69].
- Mental health is among the three leading causes of income protection claims in Australia, with approximately 10 per cent of all insurance claims drawn from superannuation attributed to mental illness and suicide[70].
- Such costs, however, cannot be understood as "just numbers or solely monetary terms". They are highly personal, pervasive, and long-lasting to people with lived experience of mental ill-

health, their families, carers, support people, and impact the broader community, governments, industries, sectors and insurers.

- People living with mental ill-health are more likely to be negatively impacted across multiple life domains. This includes poorer academic outcomes, disengagement from school, education or training, low workforce participation and higher levels of unemployment, incarceration, homelessness, co-occurring substance use problems, and poorer physical health and life expectancy compared to people without a mental disorder[71].

2.3 Social and economic impacts of alcohol and other drug use

- Alcohol use carries high social, health and economic costs, conservatively estimated at $66.8 billion nationally in 2017-18[72].
- This conservative estimation is based on pre-pandemic rates. However, there is an early indication that alcohol-related harm may be increasing through the pandemic.
- In 2015-16, opioid use, including illicit opioids and non-prescribed pharmaceutical opioids, was estimated to cost $15.76 billion. In this same year, the social cost of cannabis use was estimated to be $4.5 billion, and tobacco use was $136.9 billion[73].
- Nationally, Queensland has the second-highest emergency department presentations attributed to alcohol use; and there are 45,000 hospitalisations or over 146,000 patient days per annum. In 2015-16, approximately 11,200 hospitalisations or 48,700 patient days were attributed to drug use.
- However, research indicates effective prevention can significantly reduce individual, family and community harm from alcohol and other drugs and is a cost-effective strategy with a high return on investment ($18 return for every $1 invested). Investment in alcohol and other drugs treatment services is estimated to return $7 for every $1 invested[74].

2.4 Social and economic impact of suicide and suicidality

- The Productivity Commission (2020) conservatively estimated that the cost of suicide and non-fatal suicide attempts is approximately $30 billion per year[75]. However, it must be noted that estimates vary, and it is difficult to measure the social and emotional costs of suicide.
- In their findings, the Productivity Commission (2020)[76] estimated that such costs are divided into three broad and overarching categories: direct, indirect, and intangible[77]. They estimated:
    - each death by suicide includes average direct costs of about $134,000 and average intangible costs of approximately $9.2 million per person
    - non-fatal suicide attempts that result in permanent incapacity cost between $1.7 million to $2.1 million per person, and
    - suicide attempts resulting in a short absence from regular activity cost between $1200–$5300 per person, depending on whether they were hospitalised.
- However, each death and attempt can have far-reaching impacts on individuals, families, carers, support people, friends, colleagues, peers and the broader community. These impacts are profound, can last a lifetime, and are beyond measure[78].
- It is estimated that effective follow-up care could save 35 lives each year and prevent over 6150 suicide attempts, reducing the number of suicide attempts by up to 20 per cent[79].
- Effective aftercare is conservatively estimated to provide a long-term return-on-investment of $2.37 to $6.90 for every dollar invested[80].

Section 3: key leverage points for change

3.1 Optimising Queensland's mental health and wellbeing system

Building on solid foundations

- Queensland's mental health system has had significant investment and undergone many changes over time. It is important to acknowledge the strengths and the foundations to build reform on, this includes:
    - the shift away from institutionalisation
    - publicly funded services and support for those with the highest needs
    - a history of successful promotion, prevention and anti-stigma initiatives, and strong advocacy
    - laws and processes to promote quality improvement, human rights and consumers' rights
    - an enviable infrastructure of mental health and addiction workforce development centres
    - a committed and professional workforce including a small, but valued, peer workforce
    - primary and community support for people with mild to moderate needs, and
    - pockets of innovation—the most promising of which are often designed and delivered by people wanting to change the way things are done, including people with lived experience.

Acknowledging the challenges

- Despite such progress, it is a system that is under immense pressure and with missing critical elements. Certain groups in our community experience exposure to, and impact of risk factors known to cause mental ill health at greater levels and in unique ways. Perversely these groups are often served least well by the current system and experience higher rates of mental health problems and disorders and have reduced access to appropriate and responsive services.
- People experiencing multiple risk conditions are least likely to be well served by the current system. Further discussion of risk factors is in the later section of this submission titled 'Inequality: tackling the causes of the causes and creating a fairer foundation for mental health for all'. However, it is important to note the unique needs of the following groups:
    - Aboriginal and Torres Strait Islander people continue to experience health inequities across diverse health and wellbeing indicators within the context of colonisation, historical and intergenerational trauma, impacts of the Stolen Generations and removal of children, systemic racism, discrimination, economic and social disadvantage[81]. Aboriginal and Torres Strait Islander people are almost three times more likely to experience high or very high levels of psychological distress than other Australians, are hospitalised for mental ill-health at almost twice the rate of non-Indigenous people and have twice the rate of suicide than that of other Australians.
    - People from culturally and linguistically diverse (CALD) backgrounds, including refugees have variable access rates to mental health and support services due to a number of barriers such as high levels of stigma, poorer mental health literacy, difficulties navigating the system, as well as a lack of culturally appropriate and culturally safe mental health service options.
    - Lesbian, gay, bisexual, transgender, intersex, queer or questioning (LGBTIQ+) Queenslanders are more likely to experience stigma, prejudice, discrimination, social exclusion, and harassment and are more likely to experience and be diagnosed with a mental health condition, are more likely to have engaged in self-harm in their lifetime, are more likely to have thoughts of suicide.

- Infants, children and young people are less likely to be able to access support when needed and yet the early years of life present the best opportunity to establish positive trajectories and there is significant evidence for a strong return on prevention investment.
- Children and young people engaged with the child protection or youth justice system are more likely to experience mental ill-health and have complex needs. Current services are limited and only able to respond to those with the most acute needs when a more universal approach with a high need group could reduce longer term challenges.
- People living in regional, rural and remote communities experience mental ill-health at a similar rate to people living in major centres however people in regional, rural and remote communities face higher incidences of suicide and hospitalisations due to self-harm, which increase with relative remoteness[82].
- People with disability more likely to experience higher levels of distress, anxiety, or depression than people without disabilities and people with intellectual disabilities are two to three times more likely to experience common mental disorders[83].
- People engaged with the criminal justice system have about double the rate of mental illness than the general population[84]. An early intervention approach would help address the over-representation of people with mental illness across the criminal justice system[85].

The critical issue of system design

- Despite over 30-years of significant reform goodwill, and investment, Australia's mental health system's overarching architecture remains complex and fragmented, insufficiently defined and coordinated, and grossly under-resourced[86]. A lack of cohesive system design is compounded by:
    - the introduction of new initiatives without systemic consideration of the existing system landscape, increasing system complexity and fragmented
    - challenges in monitoring and measuring performance and outcomes, particularly whether the investment is efficiently and effectively expended in the areas of greatest impact, across clinical and non-clinical supports, and
    - increased pressures upon health and non-health systems due to sub-optimal mental health outcomes[87].
- There are known areas of urgent need that can be enhanced and supported in the short term. However, a programmatic approach alone will not address the underlying issues, and in fact risks perpetuating and deepening the current problems. Simply adding programs and services alone is not supported by the accumulated evidence.
- A longer-term and systemic approach is required that acknowledges that the effective and sustained changes that are required will depend on careful management and oversight, new ways of working, cultural change, and sustained system improvement and learning. This relies on a whole-of-system approach driven by strong and collective system leadership and accountability.
- The reform ambition is more than improving parts of the mental health system, acquittal of requirements, and requires more than system adaptation[88]. Consideration of the relationships and intersectionality of reforms and systems within and beyond the healthcare system is required.
- As highlighted by the *Royal Commission into Victoria's Mental Health System* (2021)[89], achieving system-wide transformation is further likely to be influenced by factors including:
    - clarity regarding the vision for change
    - strength and unity of the overarching leadership
    - the degree to which stakeholders, particularly people with lived experience, their families, carers and loved ones, are meaningfully engaged, and participating, and
    - a culture of learning and improvement as part of the ongoing change process.

Current system management arrangements

- Currently, the Queensland mental health system sits within the health system portfolio. It is characterised by its structural and systemic complexity, that includes interfaces within and across all tiers of government, universal access to the Medicare Benefits Scheme, private health funding, corporate and philanthropic investment, a range of service offerings, and changing funding arrangements.
- Mental health services, broader social services and support payment systems are built upon a complex network of mixed care settings and service providers with intersecting responsibility for delivery, funding, and expenditure—each with their own overarching governance, financing and regulatory approaches.
- The Mental Health, Alcohol and Other Drugs Branch (MHAODB) sits within Clinical Excellence Queensland (a division of Queensland Health) and supports the state-wide development, delivery and enhancement of safe, quality, evidence-based clinical and non-clinical services in the specialist areas of mental health and alcohol and other drugs treatment. This includes supporting and coordinating clinical and non-clinical service development and improvement, including managing and evaluating performance across Queensland.
- The MHAODB is responsible for contemporary evidence-based service planning, development and review of models of care, new programs and service delivery initiatives, and state-wide policy development. The MHAODB further meets Queensland's obligations to collect and report information, support patient safety and engagement, provide purchasing advice on system-wide specialist mental health and alcohol and other drug programs, and administer the *Mental Health Act 2016*.
- In 2013, the Commission was established as a statutory authority to drive ongoing whole-of-system reform towards a more integrated, evidence-based, recovery-oriented mental health and alcohol and other drug system in Queensland.
- Grounded within a legislative base under the *Queensland Mental Health Commission Act 2013* (the *Act*) and located within the portfolio of the Minister for Health, the four key functions of the Commission are:
    - develop, support and report on a whole-of-government Strategic Plan, including coordination, monitoring, and reporting of implementation and outcomes
    - research and report on issues relevant to Queenslanders building on the contemporary evidence-base
    - deliver and support promotion, awareness and early intervention through approaches that promote community-wide mental health and wellbeing, prevention and early intervention, awareness, and reduce stigma and discrimination, and
    - engage and enable stakeholders to foster an inclusive and responsive system.
- The *Act* further established the independent Queensland Mental Health and Drug Advisory Council to advise the Commission on mental health, alcohol and other drugs, and suicide prevention matters.
- The Queensland Mental Health Commission is one of various other mental health commissions established in other jurisdictions, that include the National Mental Health Commission, and commissions in New South Wales, South Australia and Western Australia, as well as an Office for Mental Health and Wellbeing in the Australian Capital Territory, and a Mental Health Complaints Commissioner in Victoria. While most commissions have a similar scope and remit, the Western Australian Mental Health Commission is responsible for planning and purchasing mental health and alcohol and other drugs services.

Strengthening the whole-of-system authorising environment

- Achieving long-term and enduring change requires strong and effective system leadership to advocate and drive a clear whole-of-system vision for collective impact, service improvement, and improved and meaningful consumer outcomes.
- Leadership for mental health and alcohol and other drugs outcomes is necessarily dispersed across a complex system, within government and beyond. Responsibility for mental health and wellbeing stretches beyond the mental health and broader health system. Promoting positive mental health and wellbeing is a responsibility shared across communities, systems and sectors, industries, and governments[90].
- Queensland Government agencies contribute to, and make significant investments in, services and programs to prevent and reduce the impact of mental ill-health, problematic alcohol and other drugs use, and suicide. However, no one agency, level of government, group or community can improve the mental health and wellbeing of Queenslanders alone.
- Integrated governance arrangements are necessary to harness the strengths and contribution of diverse areas, oversee resourcing, monitor and manage performance, strengthen accountability, and instil public confidence[91]. Important here is establishing and agreeing on a clear, shared vision and strategic direction, supported by strong cross-sector collaboration and a strategic approach to investment—particularly where there is compelling evidence to improve the efficient and effective allocation of finite resources[92].
- The prioritisation—and where needed—redistribution of resources across portfolios requires:
    - a shared understanding of the interdependencies and long-term effects and impacts of the social determinants of mental health and wellbeing, mental ill-health, problematic alcohol and other drugs use, and suicide, right across the care continuum
    - an agreed policy framework to guide and support cross-portfolio decision-making around resource allocation over the medium-to-longer term, and
    - reform actions that seek to prevent and reduce the impact of mental ill-health, problematic alcohol and other drugs use and suicide, and may include budgetary mechanisms to account for costs or benefits that sit outside administrative boundaries[93].
- As articulated by the *Royal Commission into Victoria's Mental Health System* (2021)[94] , transforming the mental health and wellbeing system requires strong system leadership and accountability, including the leadership of people with lived experience. With regards to the Queensland context, this includes:
    - elevating and prioritising the status of mental health and wellbeing of Queenslanders as a government priority, core to the public reform agenda
    - accountable and transparent oversight and monitoring of the performance, quality and safety of the mental health and wellbeing system across the continuum of care
    - appropriate and effective powers of monitoring and review, including authorisation to obtain data and information about service delivery, system performance and outcomes, and other information as required across government agencies
    - reporting on the progress of cross-sectoral reform
    - clear responsibility for overseeing the promotion of positive mental health and wellbeing, as well as preventing and reducing the impact of mental ill-health, problematic alcohol and other drugs use, and suicide
    - enabling lived experience leadership, participation and engagement
    - promoting and prioritising the role of families, carers and support people across the mental health and wellbeing system
    - facilitating cross-sector and cross-portfolio action within and across tiers of government, industries and the broader community, and

- leading and supporting measures that address stigma and discrimination.

- Currently in Queensland there are elements of, but not a comprehensive approach to, system leadership and integrated governance. The scale, size and complexity of mental health and alcohol and other drugs policy, planning, investment, delivery and review mechanisms far exceed the design of current governance structures. At present, there is no national nor jurisdictional ministerial forum that is suitable for leading whole-of-government strategic reform.
- Facilitating effective cross-portfolio action necessitates an authorising environment at the ministerial level[95], supported by mechanisms across portfolios to identify and jointly consider the intersectionality of policies and guide cross-sector action.
- *Our Future State: Advancing Queensland Priorities* framework (now superseded) and its governance arrangements provided solid foundations and valuable lessons for driving comprehensive cross-sector integration, coordination, monitoring and oversight. This mechanism drove coordination and alignment across strategic frameworks and cross-portfolio priorities. It facilitated joint planning, prioritising, delivery and review through an integrated structure of Ministerial Outcome Oversight Groups, Directors-General Cluster Groups and senior cross-agency working groups.
- The implementation of Queensland agency mental health, alcohol and other drugs, and suicide prevention reform actions is currently overseen and supported through the *Shifting minds* Strategic Leadership Group, which includes senior cross-agency representation. The Commission has recognised the need to consider the optimal and necessary composition, function, and positioning of the *Shifting minds* Strategic Leadership Group to drive effective system reform and has committed to further developing this in consultation with partner agencies. The Inquiry provides further impetus and highlights the need to consider this more systemically.
- In this respect consideration is also needed of the function, positioning, and reporting arrangements of the Queensland Mental Health Commission in terms of fulfilling a whole-of-government role, not just within the health portfolio.
- Experiences from other jurisdictions such as Western Australia and Victoria are useful, including the Commission reporting directly to a Minister for Mental Health with cross-portfolio responsibilities, such as the Premier or Deputy Premier. This would enable leadership of mental health at the highest levels in government, but also provides an authorising environment for the Commission to drive reform across portfolio areas and not just within health.
- In arrangements of this nature, Ministerial Charter Letters and/or Statements of Expectations would have clear responsibilities for mental health within each portfolio. The governance supporting this could build on the successful arrangement with *Advancing Queensland Priorities* where the Minister for Mental Health would convene a Ministerial Mental Health Oversight Group on a quarterly basis to monitor cross-agency progress and provide the authorising environment to the cross-government Senior Leadership Group on Mental Health to report on progress of mental health reform in accordance with an agreed road map.
- This would address some of the suggestions over many years by various stakeholders that Queensland should have a Minister for Metal Health; enable the Commission to drive mental health and alcohol and other drugs reform across portfolios; and provide a solid cross-government governance arrangement to ensure a collective approach to mental health and alcohol and other drugs is progressed in Queensland.
- Further consideration is also required of the functions and powers of the Commission both currently and within any new cross portfolio responsibility.

Recommendation 1: Elevate and embed mental health, alcohol and other drugs and suicide prevention as whole-of-government and community-wide responsibility through enhanced governance structures, planning and oversight processes. This includes the establishment of Ministerial Outcome Oversight Groups, and other mechanisms for clarifying and strengthening cross-portfolio responsibilities and accountabilities.

Recommendation 2: The powers of the Queensland Mental Health Commission be strengthened to be able to:

- interrogate and oversee cross-agency funding allocation, expenditure and client outcomes at a more granular level than currently available through annual reports and high-level national reporting
- report annually on progress of mental health reform in Queensland in accordance with *Shifting Minds* and other relevant policies and plans, including reporting to the Parliament against progress on the recommendations of the Standing Committee on Mental Health
- request any relevant, data, information and reports from government agencies to inform the development of an annual public performance report card for the mental health system in Queensland, and
- attract and hold government funds and procure programs and initiatives for a defined period, particularly in the areas of mental health promotion, illness prevention and early intervention.

3.2 State and Commonwealth mental health funding for Queensland: impacts and implications

- Funding mechanisms are a key lever and control for improving service capacity and improvements, as well as service system mix and design.
- The effectiveness of funding as a lever of improvement and reform requires clarity and agreement about intergovernmental and cross-sectoral responsibilities for funding as well as decision-making about what is funded.
- As a result of the complex nature of Commonwealth-State relations, a fragmented landscape of service providers across Commonwealth and State government, private, primary health, and non-government organisations exits.

Funding responsibilities

- Responsibilities for planning, funding, and regulating mental health services is shared between Commonwealth and state government.
- Broadly, the Commonwealth has responsibility for funding primary healthcare through general practitioners and other allied health professionals.
- It also provides mental health services for veterans through the Department of Veterans' Affairs, a range of psychosocial support and treatment services commissioned through Primary Health Networks and directly funding non-government organisations (NGOs) for community and social support programs (including suicide prevention and early intervention treatment services).
- The State government funds specialist mental health alcohol, and other drug treatment and support services through service agreements with the Hospital and Health Services and NGOs.
- This includes a range of bed-based services in hospital and communities, community treatment services as well as community support services.
- Traditionally, the role of Commonwealth and state governments centres upon the primary healthcare sector treating high prevalence mental health conditions such as anxiety and

depression, while the public mental health services focus on treating those with severe mental illnesses.

- Private-sector providers, including psychiatrists and allied professionals and bed-based mental health services are available in private hospitals and private practices.
- Though not addressed here, it must be recognised that the significant non-health expenditure through income support, aged care, disability, housing, employment, education, and justice are essential elements of the mental health and wellbeing support system.

How is funding administered?

Public sector

- Commonwealth funding is paid directly to HHSs through pool accounts managed by the National Funding Body (NFB), based largely on the volume and mix of services delivered through HHSs by a system known as Activity Based Funding (ABF).
- ABF funding provides a mechanism for driving efficiency and quality mental health services based on a payment system centred on the number and mix of patients.
- A total of $429 million was paid to Queensland HHSs in 2019-20 from the Commonwealth National Funding Body pool.
- This represents about 40 per cent of spending on all clinical (admitted and non-admitted) mental health services delivered by Queensland HHSs.
- The appropriateness of ABF funding models for mental illness is contested as there are significant variations in the treatment of people with similar levels of need which mostly stems from the disparities in service landscapes and operational environments of hospitals – rather than any differences in the clinical presentation of individuals.
- Currently, specialised community ambulatory mental health services are not funded through an ABF model rather they are block funded.
- This means that despite needed growth in the specialised community ambulatory mental health sector (community mental health services provided through public mental health services), there are no incentives in place for these services to grow nor to increase productivity.
- Across Australia, only about 29 per cent of clinical staff time at community mental health services was spent on consumer-related activities, which falls short of the benchmark target of 67 per cent[96].

Primary health

Mental health services subsidised through Medicare

- Primary health care services are funded through Medicare subsidies for GPs, allied health, and psychiatrists.
- Funding is based on mental health and other items prescribed in the MBS schedule, with the length of consultation primarily determining the funding level.
- The time-based structure of MBS payments does not fit well with the evidence on ideal models of care for mental health conditions. For example, Medicare items do not pay for time spent collaborating with other providers – which is an essential component of best practice when treating complex mental health conditions.
- A limited number of MBS items are available for addiction medicine. A range of GP education programs focussed on treatment skills in alcohol and other drugs are available to the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) members, some drug and alcohol education programs for doctors have incentives included.

- Medicare is a private practice model and is market-driven, subjecting it to significant service gaps and disincentives the provision of mental healthcare particularly for patients with chronic or complex conditions.
- The Commonwealth indexation of MBS fees for service has not kept pace with real increases in practice costs, contributing to increasing levels of out-of-pocket costs for consumers. This creates a tangible barrier to access for many consumers and impacts the viability of general practice, particularly in rural and regional areas.

Mental health services commissioned through Primary Health Networks

- The Commonwealth funds a range of mental health services through Primary Health Networks (PHNs) for a range of clinical and non-clinical supports across the mild, moderate, and severe ends of the spectrum.
- Services are funded through the Primary Health Network Mental Health Care Flexible Funding Pool through a process of commissioning, which is based on an assessment of the population health needs of a region.
- In addition to this, funds are also quarantined for headspace, headspace Early Youth Psychosis services, mental health services for Aboriginal and Torres Strait Islander peoples, and other trials and national projects according to a historical arrangement or on a fixed grant basis.
- There is an interaction between MBS rebated services and primary mental health services funded through PHNs stemming from overlaps in service provision across the two funding sources.
- The uncapped nature of MBS funding invites cost-shifting whereby services funded by the PHN are incentivised to allow MBS-rebated services to take the place of the services they would otherwise fund.
- In addition, alcohol and other drug services are commissioned through Primary Health Networks via the Australian Government Department of Health, primarily through the *National Ice Action Strategy* rollout.

Non-government sector

- State government funding to NGOs is allocated through the Department of Health through service agreements.
- These services are for a range of psychosocial supports and services in the community designed to complement specialised mental health services, especially for those in the moderate to severe ends of the spectrum who are not eligible for the NDIS.
- The Commonwealth also funds NGOs through PHNs to deliver psychosocial supports as part of the National Psychosocial Support (NPS) measure to people who are not eligible for support through the NDIS.
- State government funding to NGOs for alcohol and other drug services differs from funding for NGO mental health services. The Department of Health funds the NGO service system to provide alcohol and other drug treatment services across a range of treatment types, including specialist treatment and support services. Alcohol and other drug treatment services are also delivered by HHSs.

Private sector

- The private sector currently provides treatment for high-prevalence mental health conditions, particularly depression, anxiety, personality, eating disorders and drug and alcohol addiction.
- Private-sector services for inpatient psychiatric treatment or drug and alcohol treatment inpatient hospital stays are funded through private health insurance.
- Individuals purchase private hospital insurance to cover the cost of hospital accommodation and a portion of the medical fees.

- Extras/ancillary insurance covers out-of-hospital treatments that are not eligible for MBS rebates (such as psychology). Gap payments are usually required.
- The private health insurance market is tightly regulated by the Commonwealth. Currently private health insurers are not able to fund MBS mental health services outside of hospital. This is despite evidence showing many mental health services for high prevalence conditions could be effectively provided in the community and could prevent people from requiring hospitalisation.
- The Commonwealth government funds a 30 per cent rebate on private health insurance premiums to all persons on a means-tested basis. The Commonwealth estimate that of the mental health share of the total private hospital revenue earned through the provision of psychiatric care is 5 per cent.

What funding is allocated?

Public sector

- Over the past 20 years, the mental health-related expenditure has more than tripled ($3.1 billion in 1992-93 to $11.0 billion in 2019-20). However, spending as a proportion of health expenditure has remained unchanged and is growing at a slower rate, despite the significant number of mental health inquiries, recommendations, policies, and plans.
- The total State government expenditure on mental health services was $1.26 billion in 2019-20 (this does not include funding for alcohol and other drugs services or funding administered by ATSICCHOs) (**Table 1**).
- The estimated Queensland share of Commonwealth expenditure combined with Queensland Government spending amounts to $2.03 billion, equivalent to $393 per person. Based on this reporting approach, the State government is the major funder, accounting for approximately two thirds (62 per cent) of the total and the Commonwealth about one third (38 per cent).

Table 1. Mental health expenditure for Queensland, based on data as reported by governments, 2019-20 ($millions)[97]

Commonwealth			**Queensland Government**			**Total**
	$ million	**Per cent**		**$ million**	**Per cent**	
National programs administered through Health, Social Services, Veterans Affairs and Defence portfolios	294.3	38.5%	Public psychiatric hospitals	83.5	6.6%	
National Suicide Prevention Program	13.6	1.8%	Specialised psychiatric units in public acute hospitals	394.1	31.1%	
Indigenous social and emotional wellbeing programs	12.5	1.6%	Community mental health care services (clinical)	592.4	46.7%	
Medicare Benefits Schedule	284.6	37.2%	Residential mental health services	70.9	5.6%	
Pharmaceutical Benefits Scheme	121.8	15.9%	Grants to non-government organisations	50.7	4.0%	
Private Health Insurance Premium Rebates	36.2	4.7%	Other indirect expenditure	76.6	6.0%	
National Mental Health Commission	2.4	0.3%				
Total expenditure	**765.4**	**100.0%**		**1,268.2**	**100.0%**	**2,033.6**

- Commonwealth reported spending is a mix of transparent and opaque categories. Detailed national data for the two universal health care programs (MBS and PBS) are available, allowing accurate breakdowns for each jurisdiction. But all other categories are available publicly only at the national aggregate level and require apportionment to derive a Queensland estimate.
- More than one third (38.5 per cent) of Commonwealth reported spending is administered through four portfolios (Health, Social Services, Veterans Affairs and Defence), with the largest

component (83 per cent) being Health administered. Nationally, Commonwealth Health-administered programs are estimated to amount to $189 million for Queensland. Services commissioned through funding of the seven Queensland Primary Health Networks is estimated to account for more than half (up to 60 per cent) with the remainder directed to a wide range of other activities including digital mental health, psychosocial support for legacy clients of pre-NDIS programs, mental health promotion, stigma reduction and other national initiatives.

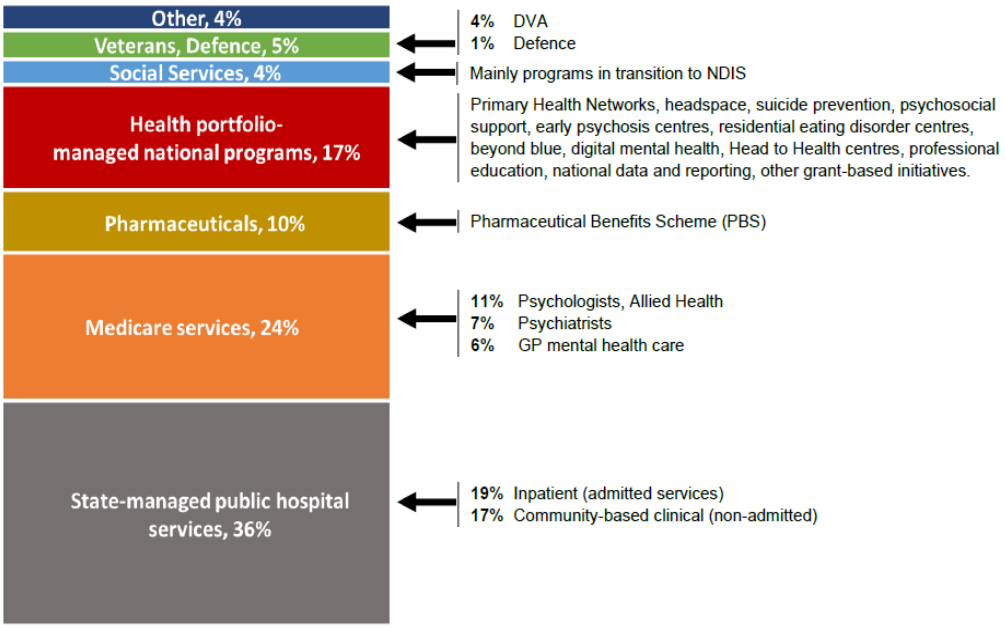
- A more accurate reflection of the total expenditure on mental health services is closer to $2.03 billion (Table 2). Of the $2.03 billion total:
    - Commonwealth share is $1.2 billion. This includes a contribution for clinical services under the National Health Reform Agreement, MBS and PBS services, a range of Commonwealth-funded programs and initiatives (including funding to PHNs), programs delivered under the Department of Social Services, and the Department of Veteran Affairs, national suicide prevention programs and other initiatives.
    - State share is $833 million. This includes inpatient, subacute and community ambulatory treatment services provided through public mental health services.

Table 2: Mental health spending in Queensland, adjusted for source of funds, 2019-20 ($millions)[98]

Commonwealth sourced			**Queensland Government sourced**			**Total**
	$ million	**Per cent**		**$ million**	**Per cent**	
Payments for State managed public mental health care – NHRA and DVA combined	434.9	36.2%	Inpatient care	245.7	29.5%	
National programs administered through Health, Social Services, Veterans Affairs and Defence portfolios	294.3	24.5%	Community mental health care services (clinical)	389.3	46.7%	
National Suicide Prevention Program	13.6	1.1%	Residential mental health services	70.9	8.5%	
Indigenous social and emotional wellbeing programmes	12.5	1.0%	Grants to non-government organisations	50.7	6.1%	
Medicare Benefits Schedule	284.6	23.7%	Other indirect expenditure	76.6	9.2%	
Pharmaceutical Benefits Scheme	121.8	10.1%				
Private Health Insurance Premium Rebates	36.2	3.0%				
National Mental Health Commission	2.4	0.2%				
Total expenditure	**1,200.3**	**100.0%**		**833.3**	**100.0%**	**2,033.6**

- The $2.03 billion figure adjusts for two Commonwealth funding streams that contribute directly to the public mental health services managed by the State government. These include payments under the National Health Reform Agreement and services delivered to veterans by public hospitals from the Department of Veteran's Affairs, which is a total of $434.9 million.
- Taking an all-governments, whole-of-Queensland perspective on mental health funding, the Commonwealth contributes 59 per cent of total government outlays on mental health with the State funding 41 per cent.
- More than one third (38.5 per cent) of Commonwealth spending is administered through four portfolios (Health, Social Services, Veterans Affairs and Defence), with the largest component (83 per cent) being health administered.
- The lack of detailed data made available in Commonwealth reporting limits the extent to which large funding bundles can be mapped to services on the ground or specific regions in Queensland.
- **Figure 9** summarises the picture that can be built from Commonwealth data released to the public domain.

Figure 9: How Commonwealth funding is spent in Queensland, 2019-20



- Payments through the National Health Reform Agreement to Queensland HHSs for the operation of specialised mental health services represent about one third (36 per cent) and is the largest component of Commonwealth outlays.
- Payments for mental health-specific services delivered through the two programs – Medicare (MBS) and the Pharmaceutical Benefits Scheme (PBS) – make up approximately another third (34 per cent) of the total.
- These are demand-driven, universal entitlement programs that provide the foundation for primary mental health care.
- MBS spending on mental health has been growing steadily since the introduction of the Better Access initiative, funding psychologists and allied health professionals who now account for the largest share of overall MBS mental health spend.
- Activities administered through the Commonwealth Department of Health (17 per cent of total) are many and varied and funded on a grant basis to organisations across Australia. Spending in this category has also grown considerably.

Primary health

- Nationally, Commonwealth Health administered programs are estimated to amount to $189 million for Queensland. Services commissioned through funding of the seven Queensland Primary Health Networks is estimated to account for more than half (up to 60 per cent), with the remainder directed to a wide range of other activities, including digital mental health, psychosocial support for legacy clients of pre-NDIS programs, mental health promotion, stigma reduction and other national initiatives.
- Funding for Queensland Primary Health Networks increased on average by 8 per cent from $137.1 million in 2020-2021 to $148.7 million in 2021-22, with Northern Queensland receiving the largest funding increase (16 per cent).
- Of the PHN funding, services for young people (which includes headspace, youth severe and early psychosis) received the most funding (34 per cent), followed by psychological therapies (20 per cent) and psychosocial support (16 per cent).
- There has been a substantial increase in funding to the primary care sector, particularly with MBS subsidised services for psychiatrists and allied health professionals since 2006.

- Expenditure for MBS subsidised mental health services in Queensland increased from $93 million in 2007-08 to $284 million in 2019-20[99].
- This has resulted in improved access for consumers and underscores the significant role primary healthcare plays in the mental health sector.
- At a national level, expenditure on mental health-specific Medicare items in major cities (across all provider types) far outweighs expenditure in regional and remote locations of Australia.
- $1.05 billion in major cities in 2019-20 compared with only $220 million in inner regional areas, $68 million in outer-regional areas, and $8 million in remote and very remote locations.
- Alcohol and other drug services are also commissioned through Primary Health Networks via the Australian Government Department of Health.

Non-government

- The state government funded a range of NGOs a total of $50.7 million (6.1 per cent of the total Queensland government contribution to the mental health budget) in 2019-20 to provide psychosocial support and specialist services tailored to specific vulnerable population groups, including eating disorders, refugees, culturally and linguistically diverse, and young children aged 0-4 years.
- Funding to NGOs in Queensland in 2019-20 has fallen since 2016-17 (which was the record investment of $95.67 million) to $50.7 million in 2019-20. There has been an average annual reduction in expenditure of 13.6 per cent. This is in part due to some programs previously funded by the State government being folded into the NDIS.
- At 2019-20, Queensland's expenditure on NGOs was $9.87 per capita compared with a national average of $15.27 per capita. This is the second-lowest per capita expenditure in Australia (with Victoria spending the lowest at $9.03).
- In response to the impacts of the pandemic, the Queensland Government's Mental Health and Wellbeing Community Package also included non-recurrent $28 million for the broader non-government sector. Sectors included but not limited to mental health, alcohol and other drugs, Aboriginal and Torres Strait Islander health and so forth.
- In 2019-20 in Queensland, more than two-thirds (68 per cent) of alcohol and other drugs agencies receiving public funding were non-government treatment agencies.
- 50 per cent of the 194 non-government alcohol and other drugs treatment services were located in major cities, followed by outer regional (21 per cent) and inner regional (19 per cent) areas. Around 11 per cent of all government treatment agencies were located in remote and very remote areas.
- In the five years to 2019–20, the number of publicly funded alcohol and other drugs treatment services in Queensland steadily increased from 158 in 2015–16 to 194 in 2019–20.

Private health

- Expenditure on inpatient and outpatient mental health services through private hospitals was $583 million in 2019-20 (average annual per cent increase of 3.2 per cent).
- This growth reflects the greater awareness of insurance holders of the availability of mental health services through the private hospital sector.
- Benefits paid by private health insurance for in-hospital mental health care claims totalled $628 million (a 3.4 per cent increase on the previous year). In addition to this, a total of $31.8 million was made for claims related to psychological services.
- As noted earlier, private insurance does not currently fund MBS services outside of hospitals. Despite evidence that many mental health services for high-prevalence conditions can be

effectively provided in the community. There is interest from Private Health Insurers to explore community-based stepped care.

- There is an increasing number of people who do not have private health insurance cover and of those who do, many policies require significant co-payments.
- This intensifies the reliance on the public mental health system, which unlike the private sector, has its growth funding essentially capped (at 6.5 per cent).

Aboriginal and Torres Strait Islander Community Controlled Health sector

- The ATSICCHO sector is primarily funded through the National Indigenous Australians Agency (NIAA), prior to 2019 the functions of the NIAA were delivered through the Department of the Prime Minister and Cabinet.
- The funding and commissioning of Aboriginal and Torres Strait Islander services should take into account the specific and distinct skill set of the Aboriginal and Torres Strait Islander social and emotional wellbeing workforce who often deliver modular and/or multiple therapeutic approaches based on local community need.
- Some funding contracts have limited support for co-design based on local community need and limit the parameters of cultural social and emotional wellbeing practices, impacting on self-determination and healing.
- The ATSICCHO sector across Queensland consistently face alcohol and other drugs and mental health related funding issues. Issues identified are as follows:
    - Lack of flexibility in funding contracts for support for the community co-design based on local community need. Funding effectiveness would increase if ATSICCHOs were able to determine local need and access funding based on this need and be genuinely consulted regarding the development of services.
    - Some funding parameters limit cultural therapy practices that can be funded which limits self-determination and healing. For example funding bodies must acknowledge cultural healing activities as therapeutic intervention and facilitate the ability to implement these activities such as payment arrangements for mentoring or on-Country activities led by Elders.
    - The Queensland Aboriginal and Islander Health Council (QAIHC) have identified that existing building infrastructure does not meet current demands and standards. A lack of capital works funding in alcohol and other drugs (particularly for residential services) has resulted in poor infrastructure and limits the expansion of services and often the infrastructure does not meet the service model.
    - The funding and commissioning of Aboriginal and Torres Strait Islander services must also account for the specific and distinct skill set of the Aboriginal and Torres Strait Islander workforce who often deliver modular and/or multiple therapeutic approaches
    - One of the nine guiding principles of the *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing 2017-2023*, identifies that racism, stigma, and social disadvantage constitute ongoing stressors and have negative impacts on Aboriginal and Torres Strait Islander mental health and wellbeing.

What are the issues?

Funding allocation

Severe shortfalls

- Total expenditure on mental health services in Queensland has not grown commensurate with population growth.
- Based on the adjusted apportioning of State and Commonwealth contributions, the combined 2019-20 Commonwealth-State funding in Queensland ($393) was below the national average ($403) and the second lowest of the jurisdictions.
- Similarly, the Queensland Government contribution ($161) was the second lowest of all the states and territories.
- Expenditure on mental health-related services represents 7.8 per cent of government health expenditure despite mental health and substance use disorders comprising the fourth largest contributor of total disease burden (12 per cent)[100].
- Despite substantial investment, the proportion of the population with mental ill-health is not decreasing. Indeed, the emergence of COVID-19 pandemic has exacerbated the many determinants of mental illness and epidemiological research has pointed to these determinants increasing the prevalence of common mental health disorders over the longer term[101].
- There are some significant shortfalls within the current service delivery system in Queensland that need to be addressed as a matter of priority. Current gaps in these areas are directly increasing the demand for acute mental health services.
- These gaps are predominantly in:
    - Residential treatment beds for adults as well as non-acute beds for older people. Queensland has a little over 50 per cent of the residential treatment beds needed to meet benchmark targets.
    - Community ambulatory mental health treatment for older people. Currently, Queensland has 20 per cent of the full time equivalent (FTE) required to meet benchmark targets.
    - The range of psychosocial supports in the community in line with strategic directions and to meet the needs of those people who are not eligible for the NDIS.
- Commonwealth programs which previously delivered psychosocial support have transitioned into the NDIS, leaving very little support for people with psychosocial disability outside the NDIS.
- Estimates from the NMHSPF suggest that 690,000 people with mental illness would have benefited from some psychosocial support in 2019-20.
- Among these are 290,000 people nationally with severe and persistent mental illness who are most in need of psychosocial support, while just 88,000 will access support upon full rollout of the NDIS by 2030[102].
- Approximately 75,000 people receive psychosocial support directly from other Australian, state and territory government-funded programs[103]. However, there is a significant gap in Australia's provision of psychosocial supports, particularly for those not receiving NDIS support.
- It is estimated that there are somewhere between 551,000 people with *significant mental illness* to 151,000 with *severe and persistent mental illness* who would benefit from psychosocial support, who are missing out[104].
- Community Mental Health Australia has estimated that an additional $610 million per year in Commonwealth Government funding is required to provide psychosocial support services to people with severe and persistent mental illness[105].

- Funding to non-government organisations rose from 2 per cent of total spending by states and territories to approximately 7.25 per cent in 2017-18.
- Contrast this with the New Zealand example, where the target for total HHS spending on psychosocial support is approximately 20-25 per cent, contributing to fewer presentations to emergency departments, fewer days in inpatient care, and reduced the rate of admission and readmission.

The 'missing middle'

- Currently, the mental health system consists of services predominantly aimed at individuals at the two ends of the continuum, that is, the mild to moderate and the severe. But the lack of clarity between Commonwealth and State responsibilities means that neither end can meet the diverse needs of the individuals accessing their services.
- There is a substantial cohort of people who are in the 'middle' - individuals whose needs are too complex or severe to be supported by primary or private health services alone, but not unwell enough to meet criteria for entry into public mental health services.
- Estimates of the quantum of this 'missing middle' are somewhere around 18 per cent of the population of people who are unwell.
- That is more than 150,000 people in Queensland who are not currently being served by either the public mental health or the primary care sectors. This estimate does not consider the fact that services across sectors are not accessed in mutual exclusivity and that consumers move across services as their needs change.
- Nonetheless, this estimate confirms what providers across sectors are increasingly recognising – that there is a cohort of people with mild to moderate severity of illness whose needs are not currently being met within the existing service system.
- Given the Commonwealth government's expanded role in funding services for individuals within the mild to moderate levels, considerable investment targeted to addressing the needs of this cohort and integrated with existing services at either ends of the spectrum is needed.

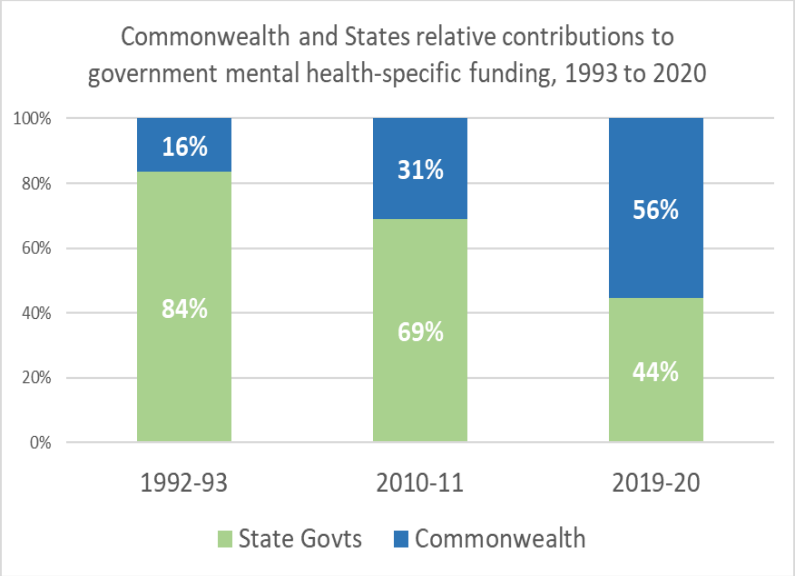
Funding administration

State-Commonwealth interface

- Commencing in the late 1990s, governments became increasingly aware of the major gap between the need for mental health care and the availability of services.
- The Commonwealth sought to fill the gap by strengthening primary care mental health services and developing population-level mental health promotion and prevention programs. Its role in funding mental health service delivery expanded substantially with the advent of the Council of Australian Governments National Action Plan on Mental Health 2006-2011.
- That plan marked the first time that a COAG-level agreement had been reached on mental health and was the largest government collective investment in new mental health.
- Some of the changes introduced by the Commonwealth were within its traditional domain.
- Most significantly, in 2006, psychologists and selected other non-medical professional groups were added to the MBS as providers of Medicare-subsidised mental health care through what became known as the Better Access program.
- In parallel, it also began funding and developing services previously the exclusive province of state and territory governments. These included, for example, personal support and day programs targeted to those with severe mental illness. In later years (2011 onwards), new Commonwealth funding emerged for early psychosis centres, adult community mental health centres, residential centres for people with eating disorders and a range of psychosocial supports for those with disability arising from mental illness.

- This has exacerbated cost-shifting between governments, particularly in relation to the expanding role of the MBS in providing care to people discharged from hospital and others in the community.
- Historical growth in the relative contribution of the Commonwealth government to mental health at the national level is shown in **Figure 10**.
- From its low base of a 16 per cent contribution in 1992-93, the Commonwealth now (2019-20) accounts for 56 per cent of all government funding for mental health nationally.

Figure 10: Relative Commonwealth-State shares of mental health-specific funding, 1993-2020



- Unsurprisingly, expanded Commonwealth funding is welcomed widely across the sector. But it has come at the price of increased fragmentation, duplication, and diminished accountability, particularly where that growth has ventured into traditional State-funded areas of service delivery.
- Mental health services in Queensland have substantial areas of responsibility that are shared or duplicated between the Commonwealth and state governments.
- As a result, the mental health system is hard to navigate, not only for clients but also for service providers. It is difficult for service providers to know who is funding what service, and in turn, very easy for governments to pass the responsibility on to a different level or part of the government.
- With regards to alcohol and other drugs, there is a lack of funding transparency and data visibility in Queensland that allows for effective mapping of funding and commissioning of services. How existing funding is allocated across the Commonwealth Department of Health via the Primary Health Networks, Queensland Health and the National Indigenous Australians Agency (NIAA) is unclear.

Siloed and misaligned allocation

- Despite the interdependent responsibilities of the Commonwealth and State governments in the treatment of individuals, services are not *operating* in an interdependent way.
- The mental health service system is not adequately set up to respond to individuals moving back and forth between Commonwealth and State-funded services.
- Greater intergovernmental and cross-departmental arrangements and approaches are needed to ensure joint planning and coordination across levels of government and portfolios to better address the social and economic determinants of mental health and wellbeing.

- Sustained and significant investment in intervening early in the course of illness and early in the lifespan is vital and will require an investment methodology attuned to a broad-ranging variety of vulnerable population groups.
- Despite the evidence that demonstrates that substantial, and potentially the greatest, shifts and savings will come from promotion, prevention and early intervention strategies, there is a lack of priority, coordinated planning, and ad-hoc investment in Queensland and nationally.
- There are specific challenges in shifting the balance of resources towards mental health promotion and prevention, even when evidence about return on investment is strong.
- A significant issue is the lack of an equitable cross-agency funding model for prevention and promotion, and robust and meaningful outcome measures relative to the diverse range of environments that are implicated.
- Where action is taken it is frequently ad hoc and time limited, and largely in the form of mental illness literacy and promoting help-seeking. While these are important there is a lack of action that deliberately and effectively target the significant social and structural drivers of, and risk factors for, mental illness.
- Mental health promotion, prevention, and early intervention outcomes, by definition, are not expected to take effect in the short to medium term, providing a disincentive for investment. The upfront costs of effective upstream interventions often rest largely on universal systems such as early childhood, education, and communities; however, the benefits are substantially shared by downstream systems such as justice, corrections, police, and health.
- Diffuse responsibility for providing psychosocial support services has resulted in poorer consumer outcomes and challenges for many NGOs in delivering services. These include:
    - funding uncertainty in one source, which can result in the overall risk of not continuing service delivery
    - different reporting requirements and contract timeframes creating administrative burden
    - current funding arrangements failing to incentivise cooperation between providers, and
    - short funding cycles limiting the effectiveness of services and hampering workforce attraction and retention.

Lack of connection between planning and funding

- Despite evidence-based strategy guiding directions and priorities for mental health reform, there is a palpable gap missing link and line of between policy intent, investment, and implementation.
- Many additional services and service models are being introduced into the system (which, although they support strategic policy directions) are allocated in a fragmented manner without consideration of the existing system landscape and how leverage could be applied to make the best use of resources. This issue goes beyond service providers merely collaborating. It is perpetuated by fundamental systemic barriers stemming from funding issues that stifle genuine integration efforts, let alone innovation.
- The objective of mental health system integration has been elusive for all reform efforts over the last three decades. Despite it being a prominent theme of all five National Mental Health Plans since the original in 1993, there has been a persistent failure to achieve integrated action between governments.
- Instead, the widening gap between policy rhetoric about governments working together and the practical reality on the ground has meant that commitments have not translated into effective collaborative action.
- If funding is to be optimally applied, ways to improve integration of services will be key to creating an efficient system. Integration must move beyond merely collaborating across sectors.

- It must involve co-funding, co-development, co-commissioning, and co-delivery of services emboldened by a shared purpose and agreed outcome measures.

Funding levers not applied optimally

- PHNs and public sector services are increasingly using the National Mental Health Service Planning Framework (NMHSPF) as a tool to support demand modelling and service planning.
- Implementation of the tool is at a developmental stage even though there is broad support for the tool to inform purchasing and commissioning.
- Ongoing tool development is required, and adjustments to the model to account for the differing needs of specific vulnerable populations are needed, particularly for rural and remote, Indigenous, forensic and culturally and linguistically diverse communities.
- A robust monitoring system must also be established alongside the framework to evaluate what is delivered against what is funded.
- The Drug Policy Modelling Program has developed the Queensland Drug and Alcohol Services Planning Model (Q-DASPM) at the University of New South Wales (UNSW). It represents a part of the process for identifying service delivery needs for alcohol and other drugs treatment services.
- Mental health commissioning and contracting arrangements are hampered by siloed decision-making, short-term contracts that create staff insecurity and inconsistent reporting and data requirements.
- Payment structures (whether through ABF or PHN commissioning) do not currently incorporate mechanisms to incentivise service delivery in ways that support reform (both in terms of addressing service gaps and changing clinician practice).
- The current approach of Commonwealth block funding for community clinical services acts as a disincentive to expand currently undersupplied community services.
- The Independent Hospital Pricing Authority (IHPA) will be introducing its casemix classification to fund inpatient mental health care from 2022 onwards, but although the IHPA has foreshadowed its intent to introduce its classification and payment model for community clinical services, a date has not yet been set as concerns have been raised about the robustness of the classification.
- The impact of the introduction of the casemix classification model to funding community clinical services is unknown but has potential to cause significant discontinuity in the Commonwealth funding of Queensland HHSs.
- Whilst all sectors increasingly realise the benefits of joint planning and co-commissioning of services, achieving this is time-consuming, and not all players participate in joint planning with the same level of capacity to effectively engage in these processes.
- The complex and holistic needs of some vulnerable population cohorts present additional challenges as market availability is an issue for some specialist services and additional resourcing to enhance service development and planning capacity is required.
- Without joint funding mechanisms, the benefits of joint planning and commissioning cannot be fully realised because there is a lack of mutual benefit and where there is an uneven playing field – there will be a tendency towards cost-shifting.
- Issues in implementing funding also stem in part from the existing system of devolved governance in mental health whereby direct service providers operate at arm's length from system managers.
- Optimal service mix will differ across regions, and the risk with having rigid governance is that a uniform approach to implementation will not address the needs of vulnerable or disadvantaged populations.

Recommendation 3: Prioritise funding to rebalance the mental health system by addressing existing undersupply, including urgent prioritisation within the following areas (but not limited to):

- additional mental health ambulatory community services and mental health beds in line with benchmark targets
- considerable increase in funding for community-based clinical and non-clinical supports, that is commensurate to population need particularly for those individuals who are not eligible for NDIS
- considerable increase in alcohol and other drugs funding across all service types
- additional new funding to develop a new front door to mental health services through models that can better meet the holistic needs of the 'missing middle' in line with benchmark targets, and
- additional investment and joint action in the early years, childhood, adolescence, and everyday life's 'big' environments, including families, schools, workplaces, and communities.

Recommendation 4: Develop new and additional funding streams to support enhanced flexibility and responsiveness to the needs of such as Aboriginal and Torres Strait Islander peoples, CALD, infants, children and young people, justice-involved, with lived experience of homelessness, and other populations with multiple comorbidities to achieve health equity.

Recommendation 5: While the issues related to developing a case-mix classification system for community clinical services is being resolved by IHPA, work with the Commonwealth Government to implement an alternative ABF system that provides incentives or growth in community clinical services to support much needed growth.

3.3 Shifting to wellbeing: promoting, preventing, and intervening early

- To improve social and economic outcomes at the individual, community, and the broader system levels mental health promotion, prevention, and early intervention must be a Queensland Government priority and a core pillar of mental health system reform.
- Effective promotion, prevention and early intervention must be supported by systemic enablers and infrastructure, including:
    - dedicated leadership, integrated cross-sector strategic planning, an appropriate investment model, and clarity of roles and responsibilities
    - action to target underlying social and structural determinants and risk and protective factors known to contribute to mental wellbeing and mental conditions, and
    - integrated efforts focused early-in-life, and during childhood and adolescence in education, workplaces and communities, supported by a mental health policy approach.
- The evidence is clear and compelling. Investing in effective mental health promotion, prevention, and early intervention will reap the rewards for individuals, communities, and all systems over time. Multiple personal, social and economic benefits are associated with improved mental health, whereas lower levels of mental health and mental health conditions have significant and long-lasting adverse effects for individuals, communities, systems and the economy.
- A healthcare or treatment approach alone has not so far—and cannot—substantially shift the prevalence of mental illness or reduce the associated distress, disruption, growing service demand and system pressures[106].

- A comprehensive and well-functioning mental health system must adopt a whole of population mental health approach focused on three elements:
    - promotion and protection of mental health and wellbeing
    - prevention of mental health conditions, and
    - provision of person-centred, holistic mental healthcare and support for people living with mental health conditions focused on enabling people to live with dignity and meaning and recover[107].
- At present, the mental health system is primarily geared to the last of these elements[108], with some prevention activity supported, however, there is very little mental health promotion at any scale or continuity.
- Mental health promotion, protection and prevention can reduce the impact of high levels of distress, disadvantage and disability, and improve social and economic participation across the population, including for people with lived experience of mental health conditions.
- It involves influencing the 'upstream' social and structural determinants and risk and protective factors influencing our mental health and supporting groups and communities who experience higher barriers to good health.
- Mental health promotion is essentially taking action to support all people to flourish. It involves actions and advocacy to address the full range of potentially modifiable determinants of mental health, including actions that allow people to adopt and maintain healthy lives and create living conditions and environments that support mental health[109]. Mental health promotion aims to improve and protect the mental health of everyone in the population while also targeting groups at known higher risk or individuals at very high risk.
- Primary prevention focuses on the entire population and aims to stop people from developing a mental health condition. It is achieved by reducing the risk factors and strengthening the protective factors associated with mental illness.
- Early intervention is about appropriate actions to lessen the impact, duration and severity of mental health conditions and specifically targets early signs and symptoms of mental ill-health. Early intervention is a form of prevention and can be directed to primary prevention among people at higher risk, or to secondary prevention.

Mental health and wellbeing is more than the absence of ill-health

- A high level of mental health, also referred to as 'flourishing', involves a combination of feeling good about, and functioning well in, all areas of life—psychologically, socially, and economically[110]. This includes the important ability to cope with the challenges of everyday life.
- Research confirms that people who are flourishing exhibit higher educational achievement, creativity, workplace productivity, better relationships, better physical health and recovery from physical and mental illness, community cohesion, and increased life expectancy[111][112].
- Positive mental health is a major individual, social and economic resource. It cannot be underestimated in its value and is not a well understood or utilised concept. The absence of mental illness does not guarantee good mental health and wellbeing. Low mental health, also referred to as languishing is the absence of feeling good about, and not functioning well in life. It involves feeling a lack of meaning, purpose or belonging in life, which leads to emptiness, lack of emotion and stagnation[113].
- While not mental illness, low mental health or languishing has been associated with substantial psychosocial impairment at levels comparable to an episode of clinical depression, greatly affecting a person's quality of life and functioning. A state of languishing can significantly impede recovery from physical or mental illness.

- Research has estimated that less than one-fifth of adults can be expected to be flourishing, around half moderately mentally healthy, and the remainder languishing[114]. This represents a substantial level of less-than-optimal functioning across the population and an elevated risk for mental health challenges. Research and anecdotal reports reveal a growing level of sadness, despair, and disengagement, particularly among young people.
- Strengthening mental wellbeing and preventing mental ill health is vital not only for the mental health sector but for broader social and economic sustainability and cohesion.

Shared determinants and influences

- Mental health challenges and disorders, and harmful substance use, are the result of many factors and include individual elements such as genetic profile, temperament, personality, and factors in the physical, social and economic environments[115].
- Risk and protective factors for mental ill-health and harmful substance use occur at individual, community, societal, and structural levels. Many of the risk and protective factors that influence the development of mental disorders are largely outside the control of the individual[116].
- Social determinants such as education, employment, family violence and poverty are underlying factors that influence wellbeing. The impacts of social determinants are complex, interactive, and cumulative, and the same social determinants often influence a whole range of social outcomes. In focusing on the social determinants of mental health and problematic alcohol and other drugs use, the same factors and responses impact across multiple portfolio areas, such as child abuse and neglect, offending and reoffending, family violence, educational underachievement, unemployment and homelessness.
- The interventions needed to prevent poor outcomes and promote wellbeing are often similar across many social problems and sectors. For example, access to affordable, secure, and stable housing contributes to child development and learning outcomes, improved management of chronic medical conditions, increased worker productivity and better mental health.
- Effective prevention and promotion yield benefits, reduces costs and improves broad individual and community outcomes across sectors and portfolios.

The whole of the community and cross-sector actions beyond health

- As is well understood, social determinants, and risk and protective factors, exist within the conditions of everyday life. While there are a wide range of risk and protective factors, some are more prevalent or have greater impact, and should be prioritised[117]. These include adverse childhood experiences, poverty and other disadvantage, loneliness, discrimination and family violence.
- The more influential factors are most effectively modified in everyday settings, such as within families, early childhood settings, schools, workplaces, and the community more broadly, as well as through policy.
- This points to the responsibility and action required across multiple departments and portfolios and all levels of government.

Key challenges and opportunities for effective PPEI

- Greater commitment, prioritisation and investment in mental health promotion and prevention strategies is required.
- We must build and maintain dedicated system enablers for a whole-of-government integrated policy approach to mental health promotion and prevention that provides clarity and commitment for investment, oversight and implementation.

Strengthening strategic leadership, governance and cross-sectoral roles and responsibilities

- Despite evidence that the greatest shifts and savings will come from promotion, prevention and early intervention strategies, there is a lack of priority, coordinated planning or investment towards it, both in Queensland and nationally.
- As previously stated, the factors with the greatest impact lie across multiple policy areas and portfolios. While mental health promotion and prevention is the business of all government portfolios, a lack of clarity about roles and responsibilities exists. This hinders engagement and accountability in a planned and coordinated cross-sector approach.
- While the core work of universal portfolios such as education, communities and employment/workplaces contribute to mental health improvement and prevention of illness, there are substantial challenges and limited mechanisms to optimise and build on their effort, and scale-up effective approaches.
- Areas for priority action can be identified based on solid evidence, including the early years, childhood, adolescence, and settings including schools, workplaces and communities.
- However, to optimise and sustain impact, Queensland requires enhanced enablers of a comprehensive prevention and promotion approach, including collective leadership, greater guidance, and oversight capability, agreed cross-agency strategic priorities, clarity of roles and accountabilities, and outcome measures.
- The *Queensland Plan for Mental Health 2003 -2017* recognised the importance and value of systemic leadership and oversight and provided the establishment of the Queensland Centre for Mental Health Promotion, Prevention and Early Intervention (QCMHPPEI). This was supported through the first, albeit modest, dedicated and recurrent budget for mental health promotion, prevention and early intervention in Queensland.
- Despite positive programmatic developments, the Centre was discontinued due to reprioritisation of investment, and the budget was absorbed into broader mental health policy support. The Commission has progressed the intent of the QCMHPPEI but without the necessary capacity.
- The commitments and approaches to mental health promotion and prevention in other jurisdictions, including Victoria, Australian Capital Territory, South Australia, and New Zealand, provide opportunity for a refreshed and prioritised mental health promotion, prevention and early intervention approach in Queensland. The areas of specific strategic focus that should be at the cornerstone of this approach are described below.
- There are solid foundations in Queensland evident across all relevant policy areas, including early childhood, health, education, housing, communities, and workplace health and safety. However, there is limited coordination or collaboration across policy areas to optimise and build on the policy and program foundations.
- In an area of such clear complexity, robust, dedicated mechanisms and capacity are required to drive and sustain integration and coordination across all points of planning, investment, delivery and review.
- The experience of *Our Future State: Advancing Queensland Priorities* and its governance arrangements provide equally pertinent insights for mental health promotion, prevention and early intervention.
- The setting of clear and shared Government objectives for the community was overseen and coordinated by a collaborative and senior cross-department governance model underpinning their delivery, along with a range of communication, monitoring and reporting processes.
- This had the effect of facilitating genuine and deep cross-agency planning and oversight of vital areas, including *give all children a great start in life*, *keeping communities safe*, *keep Queenslanders healthy*, and *create jobs in a strong economy*.

- This model also enabled rapid identification and response to opportunities for enhancement and to barriers to achieving results.
- Despite goodwill and positive cross-agency engagement, there are limited strong and compelling cross-agency planning and coordination processes to adequately support, let alone catalyse, mental health promotion and prevention and early intervenient to its potential in Queensland.
- The Department of Education Early Childhood Connect 4 Children initiative is an emerging exemplar in both strategic intent and cross-sector governance and coordination mechanisms.
- Thriving Queensland Kids Partnership is an example of a broader cross sector mechanism aiming to enable systems leadership for child wellbeing
- Systemic enablers and infrastructure are required, including dedicated system leadership, integrated cross-sector strategic planning, appropriate investment models, and clarity of roles and responsibilities.
- This includes considering the appropriate structural positioning of the mental health promotion, prevention, and early intervention systemic leadership. There are arguments for more precise separation from the health portfolio and location in a central agency, given that the modifiable factors of most influence are largely well outside the remit of the health system.

Recommendation 6: Strengthen the system leadership, governance, and cross-sectoral accountability to drive and embed mental health promotion, prevention, and early intervention as a Queensland government priority.

A mental health promotion and prevention investment model is required

- There are specific challenges to shifting the balance of resources towards mental health promotion and prevention, even when evidence about return on investment is substantial.
- A significant issue is the lack of an equitable cross-agency funding model for prevention and promotion. and the lack of robust and meaningful outcome measures relative to the diverse range of environments that are implicated. Where action is undertaken, it is frequently ad hoc and time limited, and largely related to mental illness literacy and promoting help-seeking. While these are important, there is a lack of action that deliberately and effectively targets the significant social and structural drivers of, and risk factors for, mental illness.
- Mental health promotion, prevention and early intervention outcomes, by definition, are not expected to take effect in the short-to-medium term, providing a disincentive for investment. The upfront costs of effective upstream interventions often rest largely on universal systems such as early childhood, education and communities; however, the benefits are substantially shared by downstream systems such as justice, corrections, police and health.
- An appropriate investment and outcomes strategy is required to recognise the shared value and responsibilities across all sectors; and to support effective joint planning and implementation of evidence-based initiatives and programs to the scale and quality required.
- The development and application of the investment and outcomes strategy needs to be supported by dedicated mental health promotion, prevention and early intervention system leadership, strong governance and quality oversight.
- An initial emphasis on confirming agreed priority targets and settings is required, as well as optimising current expenditure and resources through the scaled use of existing evidence-supported and quality approaches.

- This is feasible by recognising the existing foundations in place in priority areas such as perinatal and early years, education, and workplace health and safety, and ensuring adequate capacity to fully realise the potential of mental health promotion and prevention.

Recommendation 7: Develop a mental health promotion and prevention investment and outcome model that reflects the cross-sectoral benefits and responsibilities and provide strategic guidance and prioritisation.

Strategically embedding and building capacity for a wellbeing policy approach

- Consistent with *Shifting minds*, Anglicare Southern Queensland in their the submission to this inquiry (submission no 41) identifies that almost every Queensland Government department has an opportunity to contribute to the development of meaningful social connections through existing programs and initiatives. The submission further listed existing Queensland Government levers for a whole-of community 'mental wellbeing' approach, including:
    - *The Queensland Plan*, with its diverse approaches to building cohesive and inclusive communities, where people 'look out for each other'
    - opportunities offered by the new *Queensland Women's Strategy*, currently in its development phase
    - The inclusion of social connection as a measure of success in future iterations of and activity related to *My health, Queensland's future: Advancing health 2026* and the Queensland Youth Strategy
    - Expanding the initiatives under 'Reducing the cost of transport for households' in the *Queensland Transport Strategy* to explore more fully the potential for expanded concessions— supporting people on low incomes at risk of disconnection to connect more actively with their community
    - reviving the *Queensland Greenspace Strategy 2011-2020*, and including a focus on the social benefits of green space for social connection and the reduction of isolation and loneliness
    - exploring further options for individuals on community service orders that focus on building relationships as well as completing tasks
    - actively linking with community arts initiatives in *Creative Together: A 10- year Roadmap for Arts, Culture and Creativity in Queensland*, and
    - opportunities offered through *Skilling Queenslanders for Work programs.*
- Many other government strategies have a clear impact on wellbeing, and include for example:
    - *Activate! Queensland 2019-2029* through connecting physical activity to improved mental health and to promote a sense of belonging. The plan includes actions to reduce barriers to participation, enhance community connection, increase equity and attract under-represented groups.
    - *Queensland Walking Strategy 2019-2029* recognises the critical role that walking plays as part of a single integrated transport system accessible to everyone and as part of a healthy, active lifestyle for all Queenslanders.
    - Age-friendly community grants as part of the *Queensland: an age-friendly community* strategic directions statement contribute to connected and welcoming communities.
- Many more policies and initiatives can be identified across education, housing, youth justice, child safety, corrections, workplace health and safety, employment and more. Despite these important contributors, it can be argued that Queensland currently does not have appropriate mechanisms to highlight, manage or accentuate the mental health impacts of policy decisions across government.

- While there is a strong commitment across government to deliver on *Shifting minds,* there is no mechanism to require consideration of the likely mental health impacts of a new policy, strategy, or investment decisions.
- The concept of a 'wellbeing economy' is used internationally to centre mental health and wellbeing in public policy. New Zealand has developed a comprehensive wellbeing policy framework and amended the Public Finance Act 1989 to require Government to explain how wellbeing objectives guide Government's budget decisions.
- Budget documents describe how investments improve New Zealanders' living standards by tackling long-term challenges and ensuring that the things that matter most to people drive decision making[118]. A living standards framework dashboard is being used as a measurement tool to support New Zealand Treasury's advice to Ministers on priorities for improving wellbeing[119].
- The Welsh Government has established seven wellbeing goals to improve the social, economic, environmental and cultural well-being of Wales in their Wellbeing of Future Generations[120]. Forty-six national indicators have been developed to track progress against the wellbeing goals[121].
- Other counties to commit to a wellbeing economy include Finland, Iceland and Scotland[122].
- The ACT Government has also published a Wellbeing Framework to embed wellbeing in government decision making[123]. The Wellbeing Framework informs government priorities, policies, and investment decisions, including budget and cabinet decisions. A Wellbeing Impact Assessment tool has been created to support the framework, and this tool is being rolled out in cabinet and budget processes from 2021-22[124].
- The ACT Wellbeing Impact Assessment (WIA) is intended to assist the Government plan for and make decisions based on a fuller understanding of the impacts of proposals on wellbeing (including both benefits and trade-offs). This is to ensure government decision-making explicitly considers those factors that most influence the quality of life of its citizens.
- The Queensland Mental Health Commission invested in a demonstration project that tested the application of a Mental Wellbeing Impact Assessment (MWIA) via a systematic and structured assessment process that identifies how policies, programs, and services can support mental health and wellbeing. The project applied the MWIA process to three diverse sectors to demonstrate how MWIA can enable organisations to identify, demonstrate and improve their impact on mental wellbeing for staff, customers and communities.
- It is recommended that a 'mental health in all polices' approach is further considered and developed for Queensland government.

Recommendation 8: Drawing on international approaches to living standards and other tools, develop and embed a mental wellbeing impact approach across all Queensland Government policy, funding and planning.

Priority areas

- Many environments, settings and life stages demonstrate strong evidence for mental health promotion, prevention and early intervention. However, the evidence points to key areas of compelling priority because of the clear benefit they offer for individuals, communities, society, and the economy.

Priority focus: Inequality—tackling the causes of the causes and creating a fairer foundation of mental health for all

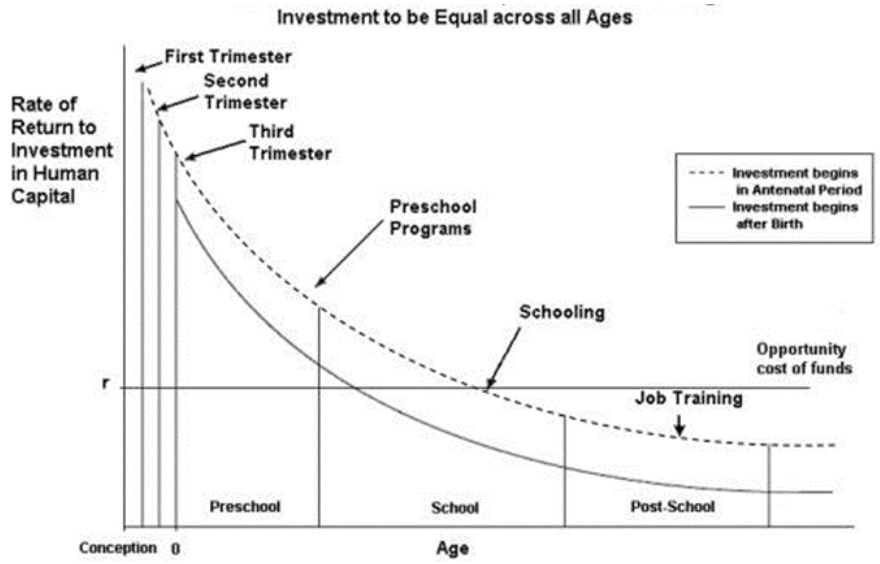
- It is increasingly clear that levels of mental distress among communities need to be understood less in terms of individual pathology, and more as a response to relative deprivation and social injustice, which erode the emotional, spiritual and intellectual resources essential to psychological wellbeing[125].
- To improve mental health and wellbeing and reduce the prevalence and impact of mental illness and harmful substance use, we must address the wider social determinants that influence mental health and broader social wellbeing.
- People are unlikely to experience wellbeing, manage distress or challenging times, or recover from mental ill-health if their basic needs are not met—including adequate food, safe environments free from abuse and violence, material security, warm and secure homes, jobs and income. The stress and trauma that people experience from lack of appropriate housing, poverty, cultural alienation, family violence, racism, and the impact of colonisation cannot—and should not—be addressed by mental health interventions alone.
- Like other areas of health, a social gradient is seen in mental health, where mental disorders are more prevalent among people who are socio-economically disadvantaged than people who are advantaged. The social gradient is not the result of intrinsic differences between advantaged and disadvantaged individuals; it is due instead to differences in access to 'critical resources for good mental health such as high-quality education, employment, financial security, stable housing, and access to health and human services'[126].
- For some groups and communities, this increased prevalence is also linked to prejudice, discrimination, reduced social and economic opportunities, and the violence they experience simply because they belong to groups with less power and influence. Significant risk factors include ongoing poverty, violence against women, racism, homophobia, and transphobia[127].
- Racism and discrimination have been identified by Aboriginal and Torres Strait Islander people as one of the main issues impacting their social and emotional wellbeing and self-esteem, and is also a barrier to services, treatments and support[128]. Policies and practices that promote equality and tackle discrimination reduce the risk of poor mental health across the community[129].
- Substantial impact and shared return across systems can be achieved by implementing coordinated policy approaches to address the underlying factors contributing to growing inequity and intergenerational disadvantage.
- Mentally healthy public policies that tackle mental health's social and economic determinants are integral to the prevention solution. Some of these policies already exist but may need to be strengthened because they are still not having their desired effect, while others are missing. Key targets should include educational attainment, income and housing security and efforts to prevent gender violence, racism, homophobia and transphobia and other forms of discrimination[130].

Priority focus: the early years - starting well and a great start in life

- Cost-benefit analyses show that investment in the early years will pay a return on investment many times over, both financially and non-financially, through increased academic achievement, enhanced health outcomes, and reduced social disruption[131]. However, where focus on the early years has occurred, it has tended to focus on the older end of this life stage, mainly pre-school age.

- The very beginning of life offers the greatest potential to impact health and wellbeing throughout life[132] and the opportunity for greatest return.
- The **first 2,000 days**, the period from conception, throughout pregnancy, and until a child's fifth birthday, is a critical window. Developmental neuroscience has established the critical role that prenatal and early brain development plays in good mental (and physical) health over a person's life, as well as in educational achievement, employment, friendships and relationships, and parenting.
- Nobel prize winning economist James Heckman calculated that when investment in prevention and early intervention services occurs from the first trimester, the return-on-investment rate is the highest, and this continues throughout the child's trajectory[133] (**Figure 11**).

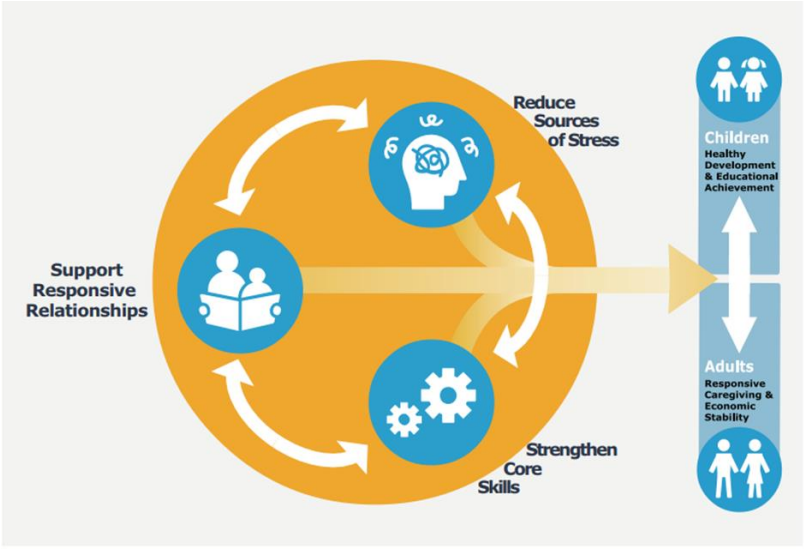
Figure 11: Rates of return to human capital investment setting



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

- Strengthening an integrated policy approach, and ensuring a continuum of responses across the universal, targeted, indicated and specialist services, provides the greatest opportunity to strengthen infant and child trajectories, and prevent and reduce the significant social and economic impacts of adversity and trauma.
- Three core principles have been identified to inform policy and program planning to improve outcomes for children and families across different sectors are identified in the diagram below (**figure 12**) [134].

Figure 12 core principles of policy and planning to improve outcomes for children and families



Responsive Relationships

- Children need responsive individual attention in their first years, and they need a lot of it. Responsive relationships early in life are 'the most important factor in building sturdy brain architecture'[135] and are an important buffer against broader sources of environmental disruption and stress. Warm, secure, and responsive attachment with the primary care givers is foundational to the infant and young child's social, emotional, physical and cognitive development. Stable, nurturing relationships influence many aspects of wellbeing and builds resilience and social skills.
- Parents and families need to be supported with time, information, skills and services to develop strong connections with their children. Responses to support responsive relationships include:
    - pre-natal parenting (and relationship) resources, support and programs
    - supportive and sustained home visitation services during pregnancy and the first year after birth, that extends to the wellbeing of the whole family as well as the health and development of the infant
    - continuing access to quality maternal and child health services inclusive of physical, social and emotional health, with early intervention for child, parent or family challenges or concerns
    - improving the quality and consistency of early childhood education and care services, including:
        - continuing family support and parenting education, and
        - parental paid leave and other financial supports for parents to be able to focus their time and energy on nurturing and parenting.
- Parental mental health is important during pregnancy and in a child's early years, so that parents can establish nurturing and loving connections during the critical times of babies' development before and after birth.
- Pregnancy and early parenting are a time in life that has a high risk of developing mental health issues or illness. Up to one in ten women experience depression during pregnancy and one in seven in the year after birth. One in ten expectant and new fathers are also estimated to experience mental health conditions in the perinatal period[136].
- Mental health challenges are problematic for the parent and their partner and associated with increased risk of emotional and behavioural disorders in their children, and later mental health problems.
- Despite being a time of risk, it is also a time of increased contact with the health system and when people are more open to accessing support, early intervention, prevention, and healing time during pregnancy. This provides an opportunity to encourage a virtuous cycle of ongoing improvement and gains in mental health and wellbeing for all family members.
- Prevention and early intervention with expectant and new parents are vital to avert child and adolescent mental health problems. This includes:
    - Programs to respond to vulnerability among expectant parents based on known risk factors including lack of social support, domestic and family violence, history of mental health conditions, not living with a partner or problematic substance use.
    - Perinatal screening for mental illness and substance use integrated across all touch points including maternity, obstetrics, general health and non-health services, as well as self-screening capacity.
    - Streamlined access to a continuum of treatment services that can prioritise and support parents who are identified as experiencing mental health or substance use issues during pregnancy or the first year of an infant's life.

Reduce stress

- The social and economic environments of early life and parenting are critical. Nurturing parenting and healthy development require stable and safe family environments and the ability to provide for material needs. Income, housing conditions, and other forms of disadvantage and hardship significantly impact on parenting and family functioning.
- Highly stressful or traumatic early life experiences can have long lasting negative consequences for a child or young person's physical, social and emotional development[137].
- Stress can be caused by issues outside the control of individuals such as poverty, systemic racism, intergenerational trauma, community violence, uncertain income, inadequate housing, harmful substance use and untreated mental illness.
- The term adverse childhood experiences (ACEs) encompass a range of traumatic experiences that may occur during pregnancy, infancy and throughout childhood and adolescence. These include child neglect and abuse; maladaptive parenting; exposure to family violence; and growing up in a household in which one or more caregivers experience severe mental ill-health, substance use problems and/or criminal behaviour resulting in incarceration. Bullying and cyberbullying during childhood and adolescence may also cause significant psychological harm and are also be considered an ACE.
- It is estimated that preventing childhood adversity will lead to a 23 per cent reduction in mood disorders, 31 per cent in anxiety disorders, 42 per cent in behavioural disorders, 28 per cent in substance disorders and 30 per cent of all disorders. Eliminating child neglect and abuse on its own could reduce the prevalence of anxiety and depression in our community by around 20–25 per cent.
- Tackling ACEs should therefore be a national mental health policy priority[138].
- Preventing the mental health impacts of ACEs on children and adolescents can take two main forms. Preventing ACEs from occurring (primary prevention) or reducing the impacts of these toxic stressors among children and adolescents who have been exposed to ACEs (early intervention). Efforts to support parents are crucial to both ACE prevention and early intervention.
- Where exposure to adversity and harm occurs, it is vital that early, quality, and continuing support is provided. Policy and program responses to reduce sources of stress and adversity include:
    - increasing paid maternity leave for both parents
    - workplaces supporting families to balance work and child rearing
    - investing in areas of concentrated disadvantage through, for example, provision of services and economic opportunity, improving healthy food supply and improving public transport options
    - reviewing the pay and conditions for people working in the early childhood sector to reduce stress and enhance ability to provide responsive care
    - making high-quality early learning more accessible for families with low income by increasing access to free childcare and kindy
    - offering a broad range of support for people experiencing domestic and family violence as well as improved interventions for perpetrators
    - policing responses that focus on reducing and preventing crimes, and investment in diversion options
    - coordinated policy action to prevent the drivers of adverse childhood experiences and trauma, and
    - embedding trauma informed ethos and practices in all settings of growing, learning and protecting.

Core skills

- The development of core skills such as relating to others, regulating emotions, feeling safe and self-soothing, planning and problem solving, commence early in life. Rich, meaningful experiences and safe and secure relationships in a child's early years are important for children's development and provide a strong foundation for lifelong learning and wellbeing. High-quality early childhood environments and programs are crucial to developing lifelong skills. Responses to strengthen core skills include:
    - provide skill-based parenting support services as part of comprehensive service models
    - build core skills into early childhood education and care environments
    - provide services and care that recognises, appreciates, and builds upon the skills people already have, and
    - create opportunities for two-generation programs to strengthen core skills in children and the adults they depend on.

Issues

- Queensland has a strong early years foundation with areas of world class innovation. However, there is variability and fragmentation in provision of vital elements across the universal, secondary and tertiary systems, and access can be dependent on where a child and family live.
- Responsibility for planning, funding, and delivering strategies, programs and services is dispersed across levels of government and sectors.
- The Queensland government can take an increased leadership role in nurturing and enhancing the mental health and wellbeing of infants and young children across the first 2000 days of life as the backbone of minimising the economic and societal impact of mental illness in Queensland.
- Investment in this area will create gains for the current generation of children living in Queensland, but also for future generations, as the societal and economic benefits will continue to grow and develop[139].
- Investment to create a cross-sector service system designed to nurture and enhance the mental health and wellbeing of infants, young children and their parents, carers and kin across the first 2000 days of life should focus on three areas:
    - integrated care pathways across the continuum of care—universal, targeted and indicated
    - workforce capacity, capability and development—both within mental health and across sectors, and
    - digital communication systems for families, communities, services and professionals.

Integrated care pathways across the first 2000 days

Universal and targeted care

- Responsive and proactive support and care in the first 2000 days is optimally provided through integrated, co-located, collaborative cross-agency services to families.
- Examples with demonstrated positive outcomes are frequently offered in the form of a ‘hub’ model with “wrap-around” access to universal, targeted and indicated levels of family-centred care across Queensland.
- A hub model enables families to access holistic ‘continuity of care and carers’, smooth transitions in care across sectors, and as needs change. Families can access more targeted and intensive care at times of higher need without the need to move to another service and building. When the level of need decreases, families return to the universal care pathway.
- An integrated care system removes siloed and fragmented services to improve individual, family and system outcomes. The ‘continuity of care and carer’ model enables connection and

relationships of trust and collaboration to build between the families and the services they access—focused on supporting infants, young children and their families to thrive and grow.

- The hub becomes a place-based service within the community, building social, cultural and community connectedness. It creates a safe place that families can access the supports and resources that they need to navigate the first 2000 days of their child's life. Stigma associated with accessing targeted and indicated levels of care is decreased, improving engagement and participation.
- At the universal and targeted level, a first 2000 days hub service optimally includes a combination of both home-visiting care and centre-based care to support family engagement with services, decrease barriers to care and build connections.
- The service offering would seek to ensure:
    - all family, kin and carers are supported to develop confidence, knowledge and capability to facilitate optimal infant mental health and wellbeing
    - infants and their family, kin and carers have access to additional support and intervention early in life, early in vulnerability and early in distress, and
    - the impact of adverse childhood experiences is minimised or mitigated through early access to care and intervention.
- Cross-agency services that lend themselves to collaborative co-location in hubs include:
    - primary health services—general practitioner, maternity and child health
    - mental health and social and emotional wellbeing services for targeted and indicated levels of care
    - allied health services
    - family support and parenting education
    - early childhood services—education and care
    - social services—housing, financial security and safety, and
    - cultural care providers and community connections.
- Entry to a hub service would commence antenatally, offering physical health via midwifery care alongside universal mental health and wellbeing care.
- Universal home-visiting care commencing antenatally and continued through the child's early years has a strong evidence base across multiple decades and countries[140].
- A combined nurse and allied health home-visiting program as a universal care option proactively supports families across the first 2000 days and enables very early response to additional physical, emotional, social and economic needs.
- There are currently small pockets of this care being provided (for example, Australian Nurse Family Partnership Program available in some Aboriginal and Torres Strait Islander Health Services) however this is not universally available for all pregnant, birthing or newly parenting families.
- Investment of this kind has resulted in the following beneficial short-term outcomes:
    - decreased rates of pre-term births
    - decreased rates of maternal tobacco use
    - increased rates of breast-feeding mothers at 6 months post-partum, and
    - increased immunisation rates.
- Long-term outcomes include:
    - decreased rates of child abuse and neglect
    - decreased rates of developmentally vulnerable children
    - reduced emergency room presentations for accidents and poisonings, and
    - decreased rates of juvenile justice presentations.

- Midwife-led continuity models provide care from the same midwife or team of midwives during the pregnancy, birth and the early parenting period, and has been shown to result in positive birthing outcomes[141].
- The benefits of specific navigator positions have also been demonstrated and aim to support families with higher level needs through the complex pathways and systems of care, aid transitions to new services, and engage with families throughout their care journeys. These positions further aim to reduce barriers to care, connect families to appropriate resources and supports in a timely manner, and empower families in their decisions.
- Utilising a continuity model with a navigator as part of the team, which includes midwifery and other services, enable women and families to commence their care within a midwifery group-practice type model, expanding into other services as the needs arise across the first 2000 days. This includes, for example, child health, early childhood education and care, and allied health, as well as housing, financial support and other social services.
- Examples of this are already underway but not accessible to all families within Queensland.

  Birthing In Our Community – Institute for Urban Indigenous Health
  Waijungbah Jajums – Gold Coast Hospital Health Service

Digital communication and information across the first 2000 days

- Stigma associated with mental health and emotional difficulties during pregnancy and early parenting can be strong within the community.
- There are strong stereotypes surrounding pregnancy, motherhood and early parenting. Some high-profile women have worked to challenge these stereotypes, for example, Jessica Rowe was a strong advocate with Beyond Blue. Significant work has also been undertaken to encourage help-seeking, however social media platforms remain a strong influencer of unrealistic perceptions of pregnancy, birthing and early parenting.
- Likewise, our community understanding of infants and their emotional world has been influenced by stereotyped misunderstandings that infants “don’t notice or don’t remember”. Science has provided overwhelming evidence that this once widely believed view is a myth. Infants are acutely aware of their relationships, experiences and environment. These relationships and experiences form the foundations of lifelong cognitive, physical, social and emotional development and skills.
- Current available resources for families such as the Raising Children Network, Children 360, Healthy Families (Beyond Blue), Kids Helpline, Starting Blocks and One Place (Queensland) provide a range of information—but they do not provide clear information about infant mental health and wellbeing.
- In the most commonly accessed national online resource – the Raising Children Network, ‘mental health’ is not included as an identified tab until the ‘pre-teen’ developmental age group. The ‘pregnancy—health and wellbeing’ tab addresses mental health for parents but fails to acknowledge the mental health and wellbeing of infants and young children.
- Work has commenced to explore the development of a resource for families, communities and service providers that focuses on the mental health and wellbeing needs of infants and young children across the first 2000 days. This resource will act as a foundation for universal messaging to promote positive mental health and wellbeing, as well as connection to other resources and services that can provide support for those who are coping, struggling or unwell.

Workforce capability and capacity across the first 2000 days

- A range of workforce groups are touchpoints for families during the first 2000 days period, including:
  - early childhood education and care—private and public
  - primary health care providers—midwives,
  - community and NGO services

  - emergency service personnel—police, ambulance
  - local government services—librarians.

- Workforce development focused on the first 2000 days from conception through to a child's fifth birthday can offer opportunities to increase awareness and understanding of the importance of the early years, including parental mental health. This would build a common language across service providers, as well as build capability to recognise, respond and refer when difficulties arise.
- The Queensland Centre for Perinatal and Infant Mental Health (QCPIMH) has a variety of workforce development initiatives across all levels of care. QCPIMH are working with the Queensland Centre for Mental Health Learning to identify opportunities to have these packages hosted within their learning management system. This would be an opportunity to complement rather than replicate other training platforms such as Emerging Minds training.
- Review and strengthening of the Queensland perinatal and infant mental health workforce development framework will create opportunities to build an early years system of care that:
  - has a common language and understanding of the importance of mental health and wellbeing across the first 2000 days
  - offers perinatal and infant mental health training pathways across the continuum of care
  - supports mentoring and supervision as part of learning pathways, and
  - supports all touchpoint cross-sector workforce groups to learn.
- An area of continuing need is how to optimally offer and ideally embed relevant levels of training and support within the workforce development strategies of non-health settings.

Addressing the cross-sector enablers to mental health and wellbeing of infants across the first 2000 days

- The first 2000 days for families are undoubtedly a time of profound physical, psychological and social transition, and each family's experience of the challenges associated with these transitions are shaped by a myriad of intersecting social factors.
- These multiple vulnerabilities and social factors intersect to create a complex web of mental health needs and treatment, and therefore must be considered with this in mind—enabling interventions and services to be sensitive to a family's experience of race, poverty, trauma, education and income.

A cross-sector approach for early years education system

- The Queensland Ed-LinQ Program (Ed-LinQ) was established in 2009 to improve linkages and service integration between the education sector, primary care, community, and mental health sectors. The goal is to support the early detection and collaborative care of school-aged children and young people at risk of—or experiencing—mental health problems or mental illness. To date, the focus has been on school-aged children.
- An opportunity exists to further enhance integration with the early childhood education and care sector through the expansion or extension of the Ed-LinQ program to include the early years sector. Early Childhood Ed-LinQ would create an opportunity to:
  - facilitate early access to infant mental health advice and pathways to care
  - enhance early childhood workforce capability around the mental health and wellbeing of infants and young children, and
  - build and strengthen relationships within the early childhood service system, to foster greater mutual understanding of respective roles and drivers and strengthen collaborative responses.

- Accessing valuable early childhood developmental programs in an educational setting is difficult for children who have delayed developmental milestones because of infant mental health struggles.
- There is substantial expertise across the perinatal and infant mental health and early years education system to support the further design and implementation of an integrated continuum of response and care. A government commitment to resourcing and authorising is required to enable this to be taken forward.
- This requires integration, coordination and leveraging of the 2021-22 Australian Government budget commitments into the establishment of Kids Head to Health centres, parenting programs and child wellbeing.

Recommendation 9: Building on existing infrastructure, develop and implement integrated first 2000 mental health and wellbeing continuum across Queensland:

- that provide access to universal, targeted and indicated levels of family-centred care
- include maternity and allied health sustained home visitation, and
- provide Hub based health, mental health, early childhood education and social services.

Recommendation 10: Develop the Early Years Ed-LinQ model to build the capacity of the early childhood education sector for early detection and collaborative responses for young children at risk of or experiencing mental health challenges.

Recommendation 11: Support and resource a First 2000 Days cross sectoral workforce capability strategy.

Priority focus: Mental health and wellbeing for children and young people

- While the early years present a critical window for improving outcomes and prevention and early intervention during childhood and adolescence, it is also a powerful opportunity to improve lifelong mental health and wellbeing.
- Most children and young people manage with the informal support of family, school and peers. However, there is evidence of increasing levels of psychological distress, mental health challenges and illness among these age groups. Although the observed increases preceded the emergence of COVID-19, the pandemic has exacerbated levels of vulnerability and distress among children and young people.
- A range of drivers and influences are contributing to the decline in child and adolescent mental health, including changes and growing stressors regarding family and parenting, education, employment, sociocultural shifts and uncertainty about the future. Further compounding factors include increasing levels of inequity and inequality, an increasing sense of isolation and loneliness reported by children and young people, increasing economic pressures on families and the negative impacts of social media and digital technologies.
- Effective mental health prometon, prevention and early intervention and wellbeing requires acknowledgment of the specific characteristics of childhood and adolescence. This includes the significant physical, cognitive, social and emotional growth that occurs during childhood and adolescence[142], and the substantial influence of the quality and security of the key environments of family, education and community.
- A developmental approach is required across the continuum of mental health promotion, prevention, and early and continuing intervention that is tailored to the specific needs and challenges of middle years, adolescence, and early adulthood.
- Key considerations for prevention and early intervention include:
  - Fifty percent of all adult mental disorders have onset by the age of 14 years, and 75 per cent before age 25 years.

- Mental health problems in infants, children and adolescents set up patterns which lead to poorer educational and employment outcomes, and poorer adult life outcomes.
- Population prevalence surveys indicate that one in seven children and young people aged four to 17 years report having one or more mental health disorders in the previous 12 months.
- Surveys show that less than a third of parents can confidently recognise the signs of a mental health problem in their child, and less than a half of parents know where to access assistance and help
- Trauma—including through child abuse and neglect, exposure to family violence, other child protection concerns, parental mental health and substance use disorders, and forced migration experiences—underpins many mental health disorders across the life course, including through infancy, childhood and adolescence.
- The combined burden of untreated and multiple mental disorders is often accompanied by social, educational disadvantage and trauma, which in turn, places avoidable demand on adult mental health, forensic and disability services. This leads to significant health care costs.

Parenting and family support

- In terms of family support:
    - The broader family environment plays a significant role in supporting and fostering good mental health and wellbeing, or conversely impacts on sense of security, material wellbeing, and opportunities for participation and optimal development.
    - Family social and economic factors must be a point of prevention, early support and intervention. This can occur through broader policy and programming regarding financial, housing, flexible work, and child support provisions, for example—as well as an opportunity to address family conflict, separation, and divorce.
- Considerations for preventing and reducing the impact of trauma and ACEs include:
    - Childhood trauma (physical, emotional, and sexual abuse, and physical and emotional neglect) can cause mental ill-health in childhood, which can carry into adulthood. Experiencing trauma negatively affects the cognitive development of children and has ongoing ramifications for their capacity to form and maintain social relationships, and to trust in possible sources of help.
    - Different types of trauma can affect children in different ways. A systematic review and analysis of the association between childhood maltreatment and suicidal behaviours, found that those with experiences of sexual abuse who were not under the care of clinicians, had higher rates of suicide attempts[143].
    - First Nations children and young people have a high risk of being exposed to trauma and continue to experience the impacts of intergenerational trauma, which contributes to high rates of mental illness.
    - Prevention and early intervention in trauma and early childhood adversity is essential to reduce negative impacts and life trajectories for individuals, but also for reducing the prevalence of mental illness.
    - Research suggests that eliminating child abuse could potentially reduce the prevalence of anxiety and depression in our community by around 20–25 per cent[144].
- Enhancing parenting skills is a key opportunity to improve outcomes for children and young people.
    - An effective way to promote the mental health and wellbeing of this group is through the key adults in their lives, particularly parents/caregivers and educators.
    - Adults require knowledge and skills to support healthy social and emotional development in children, including teaching problem solving and how to overcome challenges. Adults also play an important role in identifying and managing emerging difficulties.

  - This includes an understanding of the presentation and trajectories of mental health issues during childhood and adolescence, including the relationship with developmental, behavioural, and learning difficulties.
  - Promoting the health of infants, children, and adolescents in their homes through parental education and health promotion has a strong evidence base.
  - Parents who have access to education about positive parenting and whose own parenting needs are addressed, are more likely to show improved parenting skills, which are necessary for promoting positive development in infants, children, and adolescents[145].
  - The Queensland Government has invested in improving parental access to evidence-based parenting support, including through the Triple P program. However further tailored and responsive approaches are required to better engage and support the diverse needs and circumstances of parents.

- In terms of individual pro-social life skills and resilience building:
  - A critical task of childhood and adolescence is the acquisition of knowledge, attitudes, and skills necessary to manage emotions, set and achieve positive goals, feel, and show empathy for others, establish, and maintain positive relationships, and make responsible decisions[146]. The development of these skills provides the foundations for navigating the multiple tasks of these life stages, and into adulthood.
  - Family and community are each important for modelling and contributing to these skills, and efforts should be directed to ensuring the appropriate resources and supports are available for this purpose. A range of strongly evidence supported skill building programs exist, that include social and emotional learning (SEL) and resilience and disorder specific prevention programs[147], and are primarily delivered in education or treatment settings.
  - The preventative importance of ensuring that these programs are available across childhood and adolescence in appropriate form, quality and ‘dose’ is discussed in the following school section. However, it is also important that parents, families, and broader community are also informed and equipped to support and reinforce this vital area of social and emotional wellbeing development.

- Mental health literacy is essential for early intervention:
  - In addition to fostering mentally healthy skills and behaviour in their children, parents—as well as children and young people themselves, and their key supports in school and community settings—need to be well equipped to identify emergent vulnerability and mental health challenges early.
  - Parents widely report lack of confidence or knowledge about mental health across the continuum, including how and where to find supports and services.
  - Appropriate information, guidance and resources must be available through multiple channels. There is need for improved centralised coordination of relevant information that can be tailored to local needs or for specific cohorts.

Recommendation 12: Prioritise and integrate cross sector strategies to reduce the incidence and impact of all types of childhood adversity and trauma with an emphasis on ACEs.

Recommendation 13: Identify current activity and gaps to inform a planned approach for parent education and support for fostering mental health and wellbeing.

- Early access to responsive and integrated care and support:
    - The challenges that exist for children, young people, parents, and service providers in accessing appropriate and timely support have been extensively documented, including:
        - disconnection and fragmentation across primary, secondary, and tertiary services
        - lack of integration with social and other services
        - substantial wait times, lack of service elements in geographical areas, or lack of services that are matched to developmental or cultural needs
        - exclusion criteria based on strict clinical criteria and severity of need, resulting in very late or crisis intervention only, and
        - lack of afterhours options beyond emergency departments.
    - Community based and integrated child and family services that connect and coordinate a range of child, youth, and family systems to provide quality care and support that is matched both to need and the preference of the young person and family is important. This enables a responsive, comprehensive, and coordinated approach to mental health for infants, children, and adolescents [148].
    - It is increasingly argued that better outcomes—including ease and strength of service integration, as well as responsiveness—are enabled through service systems designed and connected according to developmental stage and need. Service approaches based on an integrated continuum of care for the early years and children (0-11 years), and separately for young people (12 years up to 25 years) are increasingly preferred.
    - Noting that it is frequently the transition points between services that pose challenges for continuity of care and support, the overarching system oversight and coordinating functions are critically important.
    - In addition to an integrated continuum of care, service design and approach must take account of the influences and frequent manifestations of mental health for the respective age groups. For example, the early years and child-oriented mental health service approach is best focused on emotional wellbeing and behavioural and developmental challenges, within an ecological frame[149]. Optimal service responses therefore strengthen the coordination and continuity of care with maternity services, paediatrics, child health, primary care, and infant and child mental health services.
    - The continuum of care for young people seeks to strengthen continuity across school-based services, and primary health and mental health services, including general practice, headspace, and online services, along with youth mental health services.

Recommendation 14: Through cross-sectoral and cross-government joint planning, design and implement community-based integrated child and youth mental health service models that provides the continuum of responses across primary, secondary, and tertiary care.

Priority focus: School-based mental health

- Schools are a crucial setting for supporting mental health and wellbeing—contributing to prevention, early detection, and support for students at risk or experiencing mental health challenges. Queensland has invested in school based mental health promotion, prevention, and early intervention since the 1990s, with different sectors and levels of government taking the lead on various initiatives.

Social and emotional skills and resilience

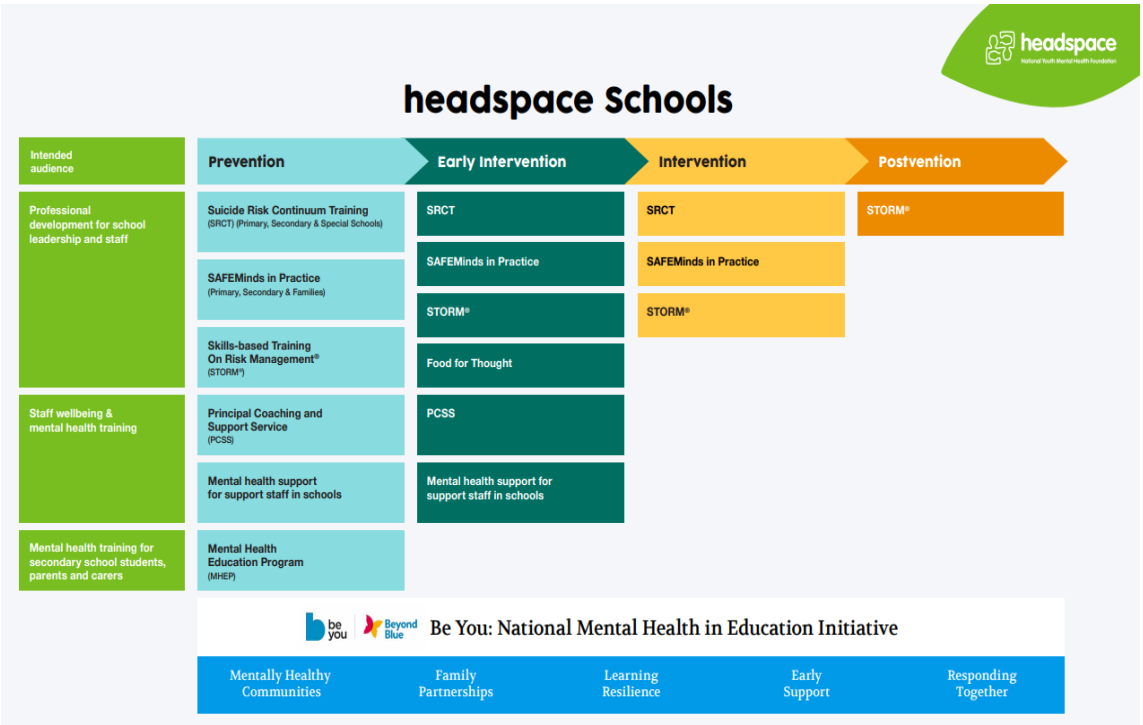
- Acquiring and mastering a range of social and emotional skills is foundational to mental health and wellbeing and to effectively navigating other developmental tasks and demands. Children

and young people who have positive peer relationships, feel a sense of belonging and connection at school and have a supportive relationship with a least one adult, tend to experience fewer mental health and substance use problems than young people without these supports.

- School-based programs to prevent mental ill health are among the most thoroughly researched prevention initiatives[150], and substantial positive returns on investment have been reported for many school-based programs[151].
- They teach children and adolescents the skills needed to build positive relationships, regulate their emotions and behaviours, solve problems, and manage life's challenges and hardships.
- As a group, the various skills-building programs are effective in increasing the mental wellbeing of children and adolescents, building resilience, and reducing the symptoms and occurrence of depression, anxiety conditions, conduct disorders and substance use problems[152].
- Systematic reviews and analysis attest to the strong and highly favourable impact that Social and Emotional Learning (SEL) and similar programs have, including for prosocial behaviour, social and emotional competence, conduct problems, emotional distress, academic performance, and prevention of mental disorders[153]. They can be delivered universally to all students or targeted to groups of children with evidence of higher needs or early signs of challenges.
- The effects of prevention are typically greater among children and adolescents at higher risk of experiencing these disorders, including those with sub-threshold symptoms, but they also have benefits across the board when used as a universal prevention measure[154].
- There is strong evidence that integrating SEL programs into a whole-school approach is a clear foundational prevention and early intervention strategy with substantial cost effectiveness.
- Whole-of-school approaches that focus on broad ethos and leadership, teaching practice, curriculum, student support programs and pastoral care, supported by pathways to external support, are more effective than single mode programs. To be effective, initiatives and programs must be well planned, integrated, well-articulated and marketed, adequately resourced, and sustained for the medium-to-long term.
- Adequate resourcing, organisational readiness and support, and the skills and knowledge of providers are important for ensuring quality and fidelity of any programs.
- The Queensland Education Student Learning and Wellbeing Framework assists schools to implement a whole-school approach to supporting students' wellbeing and mental health across the continuum—from universal promotion and prevention approaches, to targeted responses to students' mental health concerns.
- The Department of Education has been investing in a wellbeing workforce for state schools over several years. This has included employing wellbeing coaches, now called Regional Principal Advisors—Mental Health, who are a key point of contact for support and advice to principals, school leaders and regional staff right across the continuum of mental health and wellbeing. This program is innovative and responsive to the strong evidence regarding the benefits for students, staff, and school community from whole-school approaches to mental health and wellbeing.
- However, these roles have board scope, with small numbers compared to their regional coverage. A review of the advisor role and increased resourcing is strongly recommended.
- While SEL and other skills building programs are delivered in Queensland it is suggested there is significant opportunity to deepen their systematic and consistent delivery to ensure all students are equipped with vital skills and resources for life—thus preventing and reducing impacts of a range of common mental health problems, and the risk of suicide.
- There is limited information available to assess the degree to which Queensland schools are effective at integrating vital mental health curricula and programs, however it would seem more can be done to ensure that all students are supported with these vital resources.

- The Australian Government's Department of Health has a national role in developing and supporting the implementation of mental health promotion and prevention within schools.
- National programs have included *KidsMatter* (early childhood and primary versions), *MindMatters* (high school), *headspace School Support* (high school) and *Response Ability* (teacher training).
- *Be You* has since replaced all these initiatives and is positioned as the National Mental Health in Education Initiative. In 2019, the Federal Department of Health committed $98 million over four years for the implementation of *Be You*, managed by Beyond Blue. *Be You* includes a comprehensive online platform, and Early Childhood Australia, and Headspace are the *Be You* delivery partners.
- Headspace Schools, the delivery partner for *Be You*, describes itself as a national workforce that supports, engages, and partners with education and health sectors across Australia to build mental health literacy and capacity of workforces[155]. Headspace schools have some offerings for all schools, and some services for specific jurisdictions such as the enhanced mental health support for Victorian student support officers, and the Principal Coaching and Support Service for Queensland state school principals and leaders.
- The range of Headspace school programs is summarised in **Figure 13**.

Figure 13: overview of headspace Schools program



- Despite a strong Queensland *Mind Matters/KidsMatter* cross-agency governance process and engagement built over years, including dedicated Queensland Government investment support, *Be You* has no state level coordination mechanism—severely limiting any ability to optimise and tailor it for the Queensland context.
- Similarly, there are no mechanisms to enable coordination of Headspace investments across the state.
- Also at a national level, the Commonwealth Department of Education has funded the establishment of the Student Wellbeing Hub a large online resource aligned to the Australian Student Wellbeing Framework. The hub offers professional learning, webinars, and a school

wellbeing check. The hub aims to support Australian schools to be learning communities that promote student wellbeing, safety, and positive relationships, so that students can reach their full potential.

- There is a lack of integration between initiatives developed by the health sector and those developed in the education sector which creates a risk of duplication and confusion for schools.

Early intervention and school-based support

- Schools are well positioned to support the early detection of mental health challenges, as well as ensuring students are appropriately supported to maintain social and educational connections while experiencing such conditions.
- Effective early detection and intervention requires an appropriate workforce, education programs and resources, as well as reliable pathways to external community-based mental health support and responses for students and families. Ideally these services operate as an integrated continuum of support that students, families, and school staff can navigate, and access as needed.
- A range of school and regional personnel provide mental health advice and support to students and staff across the state, including guidance officers, school chaplains, school-based youth health nurses and youth support coordinators. Through an enhancement in 2018, the Specialist Guidance Officer Program was established to specifically support students experiencing mental health conditions.
- Queensland Health initiated the Ed-LinQ program in 2009 to improve the early detection and collaborative management of mental health issues affecting school-aged children and young people. Ed-LinQ includes a state-wide coordinator and Regional Ed-LinQ Coordination positions based within Child and Youth Mental Health Services.
- The Commission funded a 2014 independent evaluation of Ed-LinQ that found that the initiative had made progress in forming strategic partnerships, building capacity and providing clinical guidance. Both the education and mental health sectors identified the role of the Ed-LinQ program as crucial in facilitating timely referrals, cross agency support, workforce capability and professional development.
- The evaluation also identified that positive impacts were variable across regions and reached too few schools, due to the low level of resourcing of Ed-LinQ, the lack of consistent local and state-wide infrastructure to support the initiative, and the high level of need in schools.
- While the resourcing for Ed-LinQ has increased, the previous State Ed-LinQ cross-sector advisory mechanism was disbanded. This has diminished vital cross-agency communication, integration, accountability and oversight, and mechanisms for regional Ed-LinQ programs to seek strategic support and where needed.
- The highly valued Ed-LinQ joint professional training model was also ceased. This program brought school, mental health, child safety, youth justice and various other contributors to the care system together for joint development in child and adolescent mental health. Its value was beyond knowledge and skill building, it enabled the fostering and strengthening of collaborative management through increased understanding of respective roles and limitations, mutual respect, and the opportunity to tailor and innovate.
- Authority for collaborative cross-sector initiatives involving the departments of health, education and communities, like Ed-LinQ, need to come from government and heads of agencies, and be reinforced through actions and accountability.
- The Queensland Government has committed to enhancing support for students' mental health and wellbeing with a $100 million Student Wellbeing Package for state schools with two components:

    - a Wellbeing workforce to increase the state school wellbeing workforce by up to 464 FTE over the next three years by employing psychologists and similar wellbeing professionals, and
    - a three-year pilot of general practitioners in schools, providing students with free access to a GP at school one day per week.

- While there is significant state and national investment in student wellbeing, mechanisms to support collaboration between stakeholders is lacking, as are mechanisms to connect national investment with state-level implementation.
- Shared planning, coordination and contribution is critically needed by the Department of Education, Queensland Health, and other agencies such as child safety and youth justice, in addition to Australian Government departments with investment in this space. This could substantially enhance the ability to leverage new and existing investment and ensure the maximum reach and scale of responses is achieved.
- Specific aspects of school-focused mental health promotion and prevention can also be identified. This includes the quality and effectiveness of mental wellbeing and mental illness literacy for students and staff.
- Schools report growing numbers and complexity of students requiring support, raising the need for additional and earlier responses in schools and within the community. A systemic and tailored response—based on local needs and existing services—is required, rather than a boost to a specific service or sector state-wide.
- More tailored and embedded approaches are required that include strengthened links with relevant advice and guidance about the complex and dynamic nature of the behavioural, cognitive, emotional, and physical presentations of mental health challenges.
- Schools are also workplaces, and in the same way that the mental health of parents impacts on children, the mental health of school staff impacts on students. Staff burnout is an issue of concern raised by teachers and principals and fostering a mentally healthy workplace benefits staff as well as students.
- In 2016, the Department of Education and the Commission commenced a positive mental health and wellbeing capacity building using the evidence-based Wheel of Wellbeing (WoW) framework.
- Under the initiative, Department of Education mental health coaches, guidance officers, school principals and teaching staff were trained to apply the Wheel of Wellbeing support Queensland state schools develop wellbeing practices. Evaluation of this initiative is in Attachment 2.
- A principal of a school that participated in WoW training wrote that “building wellbeing of staff informed classroom practices, which led to a significant change in student behaviour and readiness for learning”. His reflection was that a “deliberate and intentional focus on activities that enhance my mental wellbeing and those of the children in my school is definitely now a high priority”[156].
- Positive mental health ideas and activities applied through the Wheel of Wellbeing have been used to inform school vision, principles, policies, and procedures, as well as behaviour management focused on strengths and relationships. The flexibility of the Wheel of Wellbeing framework enabled it to be well-integrated within schools and benefited the wellbeing of students and staff[157].
- As a result, a tailored program called WoW-ED was developed to align with the education sector’s strategic wellbeing priorities and approaches, and a small number of highly skilled WoW-ED advanced practitioners have been trained to support it.
- Although there was far-reaching uptake of the Wheel of Wellbeing in schools, and strong evidence of the benefit, embedding within education settings is challenging. A high-level

commitment to creating momentum for positive mental health is lacking, and although individual schools remain committed there is not support for significant spread.

- There continue to be many barriers for regional and school personnel to deliver or access quality and relevant training and development in both mental health and mental illness.
- Professional development delivered through Headspace is focused on identifying and managing signs of illness and other frequently accessed training programs—such as Youth Mental Health First Aid and ASIST—are similarly focused on response to illness and distress. Professional learning on ways to strengthen positive mental health and wellbeing, such as WoW, would complement this.

Recommendation 15: Establish a Queensland cross-sector and intergovernmental mechanism to integrate and coordinate planning, delivery, and review of a continuum of school focused mental health promotion, prevention, and early intervention, and examine opportunities for expanded integrated responses across health, education, child safety and youth justice.

Recommendation 16: Consolidate and expand the Principal Advisor - Mental Health positions and resource the program to ensure adequate focus on whole school approaches for upstream mental wellbeing and primary prevention to complement the investment in early intervention and support for students with mental health problems.

Recommendation 17: Examine the scale and quality of current approaches to SEL, mental health literacy, and mental illness literacy, and opportunities for strengthening evidence-based provision.

Priority focus: Workplace mental health

- There is a strong bi-directional relationship between work and mental health.
- Having meaningful work is important for mental health—providing structure, stimulation and challenge, an opportunity to connect with others, a sense of identity and purpose, and the financial resources to provide quality and enjoyment of life. Mentally health workplaces foster and protect the mental health and wellbeing of those who work there. However, some jobs or workplace environments can erode mental health and wellbeing contributing to substantial individual, social and economic costs.
- People in jobs or workplace environments with high levels of psychosocial risk factors are at increased risk of experiencing stress, psychological injury, or work-related mental disorders. Risk factors include:
    - low job control
    - high or low job demand
    - low role clarity
    - poor support
    - poor team climate
    - bullying and harassment
    - racism and discrimination
    - low recognition and reward
    - poor organisational justice
    - remote or isolated work
    - poor change management, and
    - exposure to trauma[158].
- Nationally, almost 25 per cent of the workforce experiences a mild depression that leads to absenteeism of 50 hours per person per year, while a further eight per cent experience moderate to severe depression leading to absenteeism of up to 138 hours per person per year[159].

- The national cost of workplace presenteeism (reduced productivity at work) and absenteeism (time off work) due to mental ill-health ranges from $13 billion to $17 billion per year[160].
- The costs of workers' compensation premiums associated with psychological injury claims are considerable and growing in Queensland and nationally. This contrasts with decreasing claims due to other injuries. At issue is not only the number of psychological injury claims, but the fact that, by nature, they are typically more costly, involve more time off work and are much less likely to be accepted[161].
- Preventing and reducing the impact of work-related mental disorders is not only morally important, but it also provides significant economic benefits. The return on investment for initiatives to create a more mentally healthy workforce have been calculated at $2.30 for every dollar invested[162]. International evidence suggests an average return on investment of $4.20 for every dollar[163].
- Placing a priority on mentally healthy work and work settings enables access to a large proportion of the population, and opportunity to address modifiable work-related protective and risk factors to prevent and reduce the impact of psychological injury across the workforce.
- Evidence-based workplace mental health strategies, resources and tools largely exist, but are not supported by adequate implementation capacity and resourcing.
- At state and National levels, there is strong support for an integrated model for mentally healthy workplaces that is based on strong empirical evidence:
    - **Protect**—identify and manage work-related risks to mental health
    - **Respond**—build capacity to identify, respond to and support people experiencing mental ill-health or distress, particularly though early intervention
    - **Promote**—recognise and enhance the positive aspects of work that contribute to good mental health[164].
- Efforts within, and integration across, all three of these pillars is critical. Focus on only one pillar, such as responding to people experiencing mental ill-health, misses the opportunity to appropriately consider how work design, organisational behaviour, management practices and other influential factors contribute to psychosocial risks.
- Despite growing interest in workplace mental health, it continues to receive less support compared to physical health and safety in the workplace[165]. While recent years has witnessed important state and national programs and strategies, they are not at scale, or supported by adequately resourced implementation to effectively meet the diverse needs of employers, industries, and sectors, and to address the complex nature of mental health and work.
- Due to the proliferation of workplace mental health resources and guidance, employers report being confused about what to do, and overwhelmed by the quantity of information provided by government agencies, NGOs, and commercial offerings'[166].
- There is a need to create strong cross-sector partnerships across the mental health, workplace health and safety, and workers compensation portfolios, and with all workplace mental health stakeholders, to plan and support effective responses tailored to need.
- There is also need for enhanced, dedicated, and tailored implementation and oversight capacity in the settings with systemic leadership capability and influence. Two major areas for coordinated focus can be identified:
    - increased capacity to support diverse sectors and work settings to understand and fulfil requirements to protect the mental health of their employees through the relevant workplace health and safety laws, and through the workers compensation schemes

  - improved coordination and integration of initiatives aimed at employers and organisations to improve the mental health of their workplace and address the potential costs of ill-health.

- The Queensland Office of Industrial Relations (OIR) identifies work-related psychological health as a priority, and designs and implements responses across the spectrum, from promotion of psychological health, prevention of injury and early intervention, to ongoing support for recovery.
- Over recent years OIR has led contemporary and innovative responses that align with and extend the workplace mental health recommendations of the National Productivity Commission Inquiry into Mental Health[167]. These include:
  - drafting a Code of Practice for *Managing the risks of work-related psychosocial hazards* to provide guidance to employers regarding key workplace risks, which is enforceable under legislation
  - legislating free early intervention, treatment, and support for psychologically injured workers until their workers' compensation claim is determined, and
  - a new streamlined pathway for first responders and other eligible employees pursuing a workers' compensation claim for post-traumatic stress disorder.
- OIR has also developed and implemented the Queensland *Mental Health at Work Action Plan* (currently being revised) and has developed and is maintaining the *Mentally healthy workplace toolkit***,** which provides guidance to help employers, managers and leaders eliminate and minimise risks to psychological health, and create workplace environments that are mentally healthy.
- Additionally, OIR led the cross-jurisdiction development of *People at work* which is the only Australian validated psychosocial risk assessment tool for workplaces.
- The People at Work tool is available online. Workplaces and businesses in Australia have free access to the People at Work survey which assesses the most common psychological hazards and gives feedback comparing organisational results against a benchmark for Australian industries.
- The strategic and regulatory functions of OIR, coupled with depth of expertise, provide a critical opportunity to more effectively prevent and reduce the impact of the leading contributors to the burden of work-related mental illness.
- Increased investment is required to enhance OIR's capacity to fulfil these functions. This includes providing appropriate implementation support for their range of initiatives including the pending Code of Practice for *Managing the risks of work-related psychosocial hazards.*
- Other Queensland Government agencies also contribute to workplace mental health.
- The Queensland *Public Service Commission* leads the public sector workforce response to this area—guiding Queensland government agencies to build competencies and develop and implement workplace mental health frameworks and action plans.
- The Department of Employment, Small Business and Training integrates mental health workplace actions and resources through its work across government and industry.
- The mental health needs of small business, including the impacts of the COVID-19 pandemic have increasingly been recognised. Small businesses are the cornerstone of communities across Queensland. Small businesses (those employing less than 20 people) account for over 97 per cent of businesses state-wide, equating to over 445,000 businesses, employing approximately 44 per cent of the Queensland workforce.
- The Queensland Chamber of Commerce and Industry (QCCI) Quarterly Pulse Survey of Business Conditions reveals continuing levels of self-reported psychosocial stressors and distress. The CCIQ's December 2021 survey found 63 per cent of businesses indicated they or one of their employees had been impacted by mental health challenges attributed to COVID-19

related stressors. This is up from 45 per cent measured in June 2021 and is indicative of an emerging and serious challenge for many Queenslanders[168].

- The establishment of a Queensland Small Business Commissioner (QSBC) within DESBT, has provided an important mechanism to integrate mental health and wellbeing supports within broader small business enhancement strategies, including in response to COVID-19 impacts.
- A collaboration between DESBT, the QSBC and the Commission has focused on increasing small business awareness and access to appropriate mental health resources and services.
- Working with Beyond Blue, the publication of A small business owner's guide to creating a mental health and wellbeing plan curated a range of business and mental health information and advice including Beyond Blue's *NewAccess for Small Business Owners* program (NASBO).
- NASBO offers a free and confidential mental health coaching program to give small business owners, including sole traders, the support to overcome difficult issues and manage stress. NASBO service data indicates that Queensland small businesses have been a top user of the service since its inception.
- The Australian Government and national programs including Beyond Blue are active leaders in workplace mental health. At a national level the Mentally Healthy Workplace Alliance established by National Mental Health Commission in 2012 is composed of national organisations from the business, union, community and government sectors "leading change to promote and create mentally healthy workplaces"[169].
- *Heads Up*—developed by *Beyond Blue* and supported by the Mentally Healthy Workplace Alliance—is a comprehensive portal with tools and resources to enable individuals and businesses to create mentally healthier workplaces. *Heads Up* provides materials for businesses, large and small, including for managers, boardroom executives and employees. It also has specific content for small businesses and for police and emergency services.
- In the 2019-20 Federal Budget, the Commonwealth announced an investment of $11.5 million over four years for the National Workplace Mental Health Initiative, led by the National Mental Health Commission. In September 2021, the National Workplace Mental Health Initiative released a Blueprint for Mentally Healthy Workplaces for consultation[170]. The blueprint is intended to create a nationally consistent approach to mentally healthy workplaces.
- Also at a national level, the Australian Treasury funded Ahead for Business a digital hub for small businesses; and Safe Work Australia provides guidance on meeting work-related psychological health and safety requirements.
- While there is large amount of activity at a national level to drive workplace mental health and wellbeing, connections with state organisations and leadership are missing. The Mentally Healthy Workplace Alliance, which is central to many initiatives, is composed of peaks and national organisations without state or territory representation. The lack of connection between national and state initiatives, including on the National Workplace Mental Health Initiative, frustrates opportunities to integrate, or work to maximise the strengths and connections of different organisations and arms of government for shared gain.
- Queensland has strong strategic and operational workplace mental health capability, but strengthened systemic leadership and coordination is required.
- In addition to enhancing the mental health promotion, prevention and early intervention (MHPPEI) leadership as discussed earlier, dedicated resourcing is required beyond the mental health sector to help drive desired workplace mental health outcomes including in OIR and DESBT. Workplace risk factors and opportunities for real improvement lie in issues such as work design, workload management, work control, pace, scheduling and culture— which require the expertise of others beyond the mental health sector.

- This would enable genuine partnership to plan and implement a comprehensive workplace mental health agenda in Queensland, in collaboration with national stakeholders.
- Dedicated resourcing is required—not to develop new tools or resources—but to provide the enabling system of practical and tailored guidance and support to translate knowledge into practice across workplaces in Queensland.
- Priority also needs to be given to reducing inequality and ensuring support is targeted to the industries, workplaces, sectors, and geographical areas where it is more challenging to embed mentally healthy workplace practices, and compliance with benchmarks and standards.

Recommendation 18: Consistent with the Productivity Commission recommendation (7.1) consider the strategic, investment, and governance implications of making psychological health and safety as important as workplace health and safety.

Recommendation 19: Invest in systemic workplace mental health leadership and increased capacity in agencies including OIR for a comprehensive approach to support industries and sectors to understand and fulfil requirements to protect the mental health of their employees through the relevant regulations and laws.

Recommendation 20: Ensure Queensland has the strategic leadership capacity to strengthen state and national partnerships to improve coordination and integration of initiatives aimed at employers and organisations to improve the mental health of their workplace and address the potential costs of ill-health.

Priority focus: Mental health and wellbeing in the community

- Communities are much more than places to live, or groups of individuals. The way communities are planned and designed, including the physical and social infrastructure, and the processes, dynamics, and values that operate are powerful contributors to individual and collective mental wellbeing.
- Communities therefore can contribute to wellbeing, have a key role in preventing and reducing risk factors including social isolation and loneliness, and can foster understanding and skills for early action.
- Many areas and considerations are possible regarding community as a key environment, and this submission will outline the following key areas:
    - supportive and inclusive environments
    - social isolation and loneliness
    - mental health and mental illness literacy, and wellbeing capacity.
- **Supportive and inclusive environments** set the conditions for good mental health and wellbeing, and support prevention and recovery from mental illness.

  "*In the same way we need appropriate health and mental health services to help individuals living with a mental illness, we also need high quality* ***social*** *and* ***community infrastructure*** *to promote and maintain our mental wellbeing at a community level. This includes schools, parks, libraries, footpaths, theatres, youth facilities, shops, play groups, restaurants, places of worship, Indigenous cultural centres, community sporting clubs, public gathering places and more.*"[171]
- Ordinary spaces and everyday life settings exert substantial influence over the mental health and wellbeing of individuals and groups. In many respects, people's lives are most acutely influenced at the local level—in their neighbourhoods and communities.
- The **Centre for Urban Design and Mental Health** has identified four key elements of physical spaces that particularly impact on mental health:

- **Green places**: There is substantial literature on the association between exposure to nature and health[172], and while there is a need to gain more understanding of how the interaction works and in what circumstances, ensuring access to nature and to green spaces remains a way in which planning our communities can incorporate mental health.
- **Active places:** Physical activity promotes mental wellbeing, can act as a protective factor for mental illness and has been shown to be an effective treatment for depression[173]. Designing for physical activity means providing good walking and cycling conditions and high-quality public transport, parks, and recreational facilities, as well as appropriate community sport and recreation programs[174].
- **Pro-social places**: Public spaces that promote community and encourage positive interactions among people offer a positive mental health benefit[175].
- **Safe places:** A sense of safety and security is important to people's mental wellbeing. Real or perceived fear of crime tends to increase stress and distrust, which reduces mental health and happiness[176].

- There are examples of systemic and innovative initiatives addressing vital aspects of community capital and design, and other known protective factors for mental health and wellbeing. However, good practice examples are infrequently integrated or embedded, which reduces the impact of the innovation. Longer term commitment, with dedicated funding and attention, is required to adequately sustain the positive impacts and outcomes required.

Social isolation:

- Being included socially and connected with others builds positive mental health.
- The Productivity Commission's (2020)[177] highlighted the importance of loneliness and social isolation for mental illness and suicide. Loneliness and social isolation can affect anyone, at any age. Internationally, loneliness and social isolation are clearly recognised as significant threats to public health, important targets for prevention of mental and physical ill-health, and major contributors to health system costs. People who are socially isolated are more likely to have higher levels of distress and mental ill-health[178].
- The Queensland Government has recognised the importance of this issue including through the 2021 Community Support and Services Committee inquiry into social isolation and loneliness in Queensland. The 196 submissions made to the Inquiry came from a broad range of organisations and highlighted the existing commitment from government and non-government organisations, and opportunities for a more coordinated and joined up response across the state.
- The contributions of key sectors to community mental health and resilience were emphasised, including state government agencies, local government, and primary care. Key points included:
    - The role of local governments in developing social cohesion and community connectedness is particularly important, and many local governments provide programs and support community interest groups through funding and capacity building[179].
    - Support includes access to council facilities and amenities; assistance to community groups including governance support, grants, and community capacity building; community programs such as the connected communities' program, *Know your Neighbour* program and *Healthy Active* program; and disaster management and homelessness programs, for example.
    - Commonwealth-funded Primary Health Networks (PHNs), contribute at a community level across Queensland with exemplars from each of the PHNs identifiable. Examples from PHNs included: *Community Peer Navigation Programs*; social prescribing; joint commissioning; and strategies and programs for specific population groups such as seniors or veterans[180]. The PHN submission noted that "while service delivery is widely funded, community development activities are not"; and it identified

that "neighbourhood and community centres, properly resourced, have a key role in building local communities and bringing people together"[181].

- The Department of Communities, Housing and Digital Economy plays a critical role in improving social and economic outcomes for Queenslanders at the community level through neighbourhood and community centres, championing place-based and community-led solutions to social disadvantage and providing support to vulnerable Queenslanders.
- Critical community assets for building community connections include Men's Sheds, Meals on Wheels, service organisations such as Lions and Rotary, groups such as Older Men New Ideas (OMNI), the Country Women's Association, University of the Third Age, playgroups, community exercise groups, community events and festivals, and so much more.
- A significant asset in Queensland is the network of 127 state-funded neighbourhood and community centres in rural, remote, and urban communities[182]. The Inquiry into social isolation and loneliness identified that Neighbourhood and Community Centres could play a key role in responding to social isolation and loneliness and recommended a review of the funding model.
- Neighbourhood and Community Centres can support mental health and wellbeing and build literacy and capacity in the community.
- At a community level, the variety of funding streams disincentivises a planned approach to understanding and responding to community needs. Funding opportunities are often available in short windows using a competitive process that works against effective collaboration and planning. A challenge is that funding from different levels of government is allocated for issues and systems rather than as a response to a broader determinant that may contribute to several outcomes. The issues arising from siloed approaches was demonstrated in a magnified way in an inquiry into service delivery in remote and discrete Indigenous Communities.
- The commitment by the Department of Communities, Housing and Digital Economy to development of a social isolation and loneliness strategy creates a key opportunity to develop a joined-up approach and address system barriers to more effective responses to social isolation and loneliness.

Mentally healthy ageing

- Good mental health and wellbeing are critical to healthy ageing, and older people require access to the full spectrum of mental health and wellbeing treatment, care, and support, ranging from prevention to early intervention and clinical care[183]. Efforts to support good mental health for older people should:
    - promote independence, dignity and quality-of-life outcomes for older people, their families, carers, and support people
    - care must be aligned with contemporary best practice in mental health, aged care, and disability services
    - care must be recovery-oriented, person-centred, high-quality, and safe, and promote family and carer involvement and enablement
    - liaison between mental health, social services and community providers regarding treatment, care and support should be facilitated to enable close coordination and continuity of care, and
    - recognition and respect for the roles and needs of older Aboriginal and Torres Strait Islander peoples, with the full awareness that such concepts are integrated into broader social and emotional wellbeing[184].
- While most older people have good mental health and wellbeing, mental ill-health is common, with many at risk of developing mental health disorders, neurological disorders, problematic alcohol and other drugs use, and other physical health conditions, including diabetes, hearing loss and osteoarthritis[185].
- Factors that may increase the risk of an older person developing mental ill-health include:

  - physical health problems and conditions
  - chronic pain
  - side-effects from medications
  - grief and loss stemming from relationships, autonomy and independence, work and income, self-worth, mobility, and flexibility
  - social isolation
  - significant changes in living arrangements
  - admission to hospital, and
  - anniversaries and the associated memories[186].

- As people age, they are more likely to be exposed to causes and risk factors for social isolation compared to other life stages, such as: socioeconomic disadvantage which restricts social activities, living alone, loss of relationships, for example through the death of a partner; disability and/or chronic health conditions.
- Strategies to prevent social isolation and loneliness contribute to maintaining quality of life outcomes for older people. The development of a social isolation and loneliness strategy should prioritise older Queenslanders.
- Initiatives that are based on intergenerational reciprocity approaches for example those that connect children with older persons offer a way to enhance wellbeing across generations. Investment in innovative initiatives such as this, linking older and young generations, is worth further investigation.

Recommendation 21: Strengthen the MHPPEI alignment with the Queensland Government commitment to develop a develop of a social isolation and loneliness strategy

Knowledge and skills: Mental health literacy

Individual and place-based approaches

- Communities with high levels of mental health literacy, including understanding of positive mental health and wellbeing, create a safer environment that is protective of mental health. Good mental health literacy is about having the knowledge, understanding and skills needed to obtain and maintain positive mental health, understand mental disorders, where to seek help and the skills to self-manage mental illness[187].
- Good health literacy helps people stay well, recover from illness or injury, and live well with one or more long-term conditions[188]. Health literacy creates an ability for people to help themselves and others. Mental health literacy can also work to reduce the stigma and discrimination around mental illness.
- Lower levels of mental health literacy can make it difficult for people to recognise the signs of distress in themselves or others in their community, and this can stop them from seeking support or being supportive.
- To date, investment in mental health literacy in Queensland and nationally has primarily focused on identifying and responding to mental illness and encouraging help seeking behaviours.
- Programs like Mental Health First Aid (MHFA) and Applied Suicide Intervention Skills Training (ASIST) teach people how to respond and provide immediate assistance to people experiencing mental ill-health or distress. These programs are based on extensive research; however, this necessitates a consistent approach to delivery. Some courses are delivered over multiple days, and costs can be a barrier, as can the inability to tailor training to specific learning needs. They are also based on clinical categorisations of mental health, and therefore may not be matched to the needs of some groups.

- There is growing demand in the community to know more about how to develop and maintain good mental health, as well as how to respond earlier to someone experiencing distress or challenges.
- People who have frequent contact with community members work in many different roles: librarians, elected representatives and their staff, accountants, hairdressers, as well as front line community services in housing, unemployment, and many more. People in such varied sectors and settings are better served by tailored training that is responsive to specific circumstances and contexts and delivered in a manner that enables people to participate more easily.
- Programs such as Connecting with People (CwP) and Conversations Matter, are promising for meeting a greater range of needs articulated by communities.
- Delivery of tailored, fit for purpose mental health literacy to targeted groups across Queensland is one element of a renewed promotion and prevention program of offerings.
- The two main approaches to improving positive mental health and wellbeing are programs designed to change individual attitudes, skills, and behaviours; and programs designed to change the context or environment[189]. The Commission's approach has been to combine these approaches by linking training for individuals with an understanding of the determinants of mental wellbeing to encourage leadership and change for families, communities, and workplaces.
- Mental wellbeing initiatives that encompass knowledge and skills in emotional and physical wellbeing and community engagement including: 'Act, Belong Connect', '5 ways to Well Being' and 'Wheel of Wellbeing'.
- The Commission has progressed initiatives that have primarily drawn on WoW, a flexible framework that addresses the six universal themes that contribute to mental health and wellbeing: Body, Mind, Spirit, People, Place and Planet. WoW offers practical skills and aligns with the mental wellbeing impact assessment tool which enables people to identify determinants of wellbeing at macro and micro levels.
- WoW was a key platform of the cross-sector wellbeing capacity building project between 2016-2020. The project engaged stakeholders across the education, health and community, government, and business sectors, and worked systemically in local communities to improve positive mental health awareness, knowledge and skills using the Wheel of Wellbeing.
- Evaluation of the wellbeing capacity building initiative identified the following highlights:
    - individuals exposed to WoW thinking and practice had an increased understanding of the science behind health and wellness. They also reported increased awareness about, and participation in activities which support their health and wellbeing
    - improved health and wellbeing were reported following exposure to the WoW framework. Improved relationships, reduced stress, and anxiety, increased physical activity and healthy eating were commonly reported, and
    - unintended positive consequences identified through the project included strengthening organisational relationships, more collaborative working in local communities, and use of WoW resources to support people during the COVID 19 pandemic.
- The evaluation of the wellbeing capacity building project found that the initiative-built motivation and behaviour change to support improved health and wellbeing; and people who participated in the workshops frequently shared their new knowledge with others. People shared information to their families and to organisations, systems, and broader community settings, creating significant momentum for positive mental health[190] (**Appendix 2**).
- Since the funded wellbeing capacity project completed, further delivery and capacity building has occurred in key settings including education regions, and in some communities where extremely positive and powerful impacts were reported. However, there are continued challenges and

barriers experienced by the WoW advocates and practitioners given a lack of funding and other support.

- The Commission piloted regional community mental health and wellbeing hubs from 2017 to 2020 to drive locally led approaches to improving awareness, knowledge, and capacity for positive mental health.
- The Commission partnered with CentacareCQ and Relationships Australia Queensland to establish the mental health and wellbeing hubs in the Central Highlands, Logan and Southern Moreton Bay Islands, North Queensland, and later in Far North Queensland.
- The hubs each developed in ways that were responsive to local strengths, needs and leadership. Each hub adopted the WoW framework and there was strong uptake of WoW training and activities. People reported that the WoW was practical, easy to understand, and the framework created a language for discussion of wellbeing.
- Independent evaluation of the mental health and wellbeing hubs in 2019 reported that the hubs achieved the intended outcomes of improving local mental health awareness, capacity, and coordination. The evaluation emphasised that communities were well-equipped to identify and drive solutions to fit their needs.
- The evaluation also noted that the hubs required adequate ongoing resourcing and support to be maintained[191].
- The current Facebook banner for the Central QLD Wellbeing Hub Inc sums up the vision of the regional wellbeing hubs “Resilient communities that support individuals to flourish – Community supporting community”.
- Mentally Healthy City Townsville is a community-led initiative that has engaged a diverse group of local people and organisations committed to supporting the Mentally Healthy City Townsville charter and vision. Mentally Healthy City Townsville demonstrates that the community is a resource for enhancing positive mental health and wellbeing. This initiative commenced in 2018 and currently receives financial support through a range of short-term commitments. An appropriate longer funding source is unclear.
- Responsibility for community wellbeing cuts across many sectors. The Commission has a strategic leadership role but is not resourced to provide services. Initiatives such as the Regional Wellbeing Hubs, wellbeing capacity building and Mentally Healthy City initiatives do not have a clear and ongoing funding source.

Recommendation 22: Continue investment in cross-sectoral engagement in mental wellbeing capacity building at the regional and local levels drawing on the insights from the Wheel of Wellbeing and Regional Mental Health and Wellbeing Hubs demonstration work and support community led initiatives.

Integrated campaigns and digital technology

- The Queensland Government has a strong record of integrated campaigns to support improved community awareness and understanding of mental health and associated issues, provide resources and guidance, and links to services.
- In addition, the Queensland Government has a long-standing arrangement with *Beyond Blue* to work with the community to improve mental health and prevent suicide. Since the commencement of this arrangement, Beyond Blue has substantially increased the range of sources, platforms, and programs it offers nationally and in Queensland.
- Over recent years Beyond Blue has developed its offering to position itself as a trusted source of information, advice and support for the community, no matter where they are on the mental

health continuum. Currently this work focuses on the three priorities set out in 'Beyond 2020', Beyond Blue's Strategic Plan 2020 –2023, which commenced on 1 July 2020:

  - Promoting mental health and wellbeing
  - Being a trusted source of information and support
  - Working together to prevent suicide.

- As part of the Beyond 2020 Strategy, the program is reimagining their engagement with the community as a 'Big Blue Door', always open for people to connect with others and get reliable information, advice, and support.
- Beyond Blue has been an important and trusted source of information and advice during the continuing impacts of the coronavirus (COVID-19) pandemic with a 20 per cent increase in website sessions in this reporting period, and Queensland traffic increasing by 6.3 percent. The number of resources downloaded nationally has also increased by approximately 27.2 percent in this period.
- Through a range of services such as the Beyond Blue Support Service (BBSS), Coronavirus Mental Wellbeing Support Service (CMWSS), NewAccess for Small Business Owners (NASBO), *Be You*, and The Way Back Support Service (TWBSS), Beyond Blue provides support to many people across Queensland.
- Demand for the BBSS and the CMWSS remained steady during this reporting period compared with the previous period. An emerging trend in this reporting period has been the significant increase in demand for webchat contact, with an increase of 59 percent in this reporting period for the BBSS, and 16 percent for the CMWSS.
- Demand continues to be significantly higher than pre-pandemic levels, with 18.6 percent more contacts to the two support services in this reporting period compared to the corresponding period in 2019. This shows that the mental health impacts of the pandemic continue to be experienced across the country, resulting in increased demand for mental health services. In short, we now have a 'new normal' level of demand. The most common reasons for contacting Beyond Blue are due to concerns about anxiety, worry, depression, and concerns for oneself and community.
- The Commission is committed to continuing to strengthen the collaboration with Beyond Blue to ensure Queensland's mental health literacy needs are optimally supported through the Beyond Blue service offering.
- Queensland has led innovation in using digital technology for improving population mental health and wellbeing. In January 2020, the Department of Health launched Queensland's first positive mental wellbeing campaign, *Dear Mind*. The Queensland Health campaign encourages Queensland adults to prioritise and support their mental wellbeing, by doing a range of evidence-based activities such as spending time with family and friends, learning new things, being active and spending time in nature to improve their mental wellbeing.
- The campaigns' key messages for Queenslanders were developed with formative research in 2017 and in partnership with the Commission. The campaign is built around the six building blocks of mental wellbeing, which provide the foundation for activities that improve mental wellbeing and are based on frameworks such as the Wheel of Wellbeing and Five Ways to Wellbeing [192&193].
- A campaign website provides links to resources and support services. A research tracker has been used to evaluate the campaign and track changes in the attitudes, beliefs, and behaviours of Queenslanders over time. Data from Queensland Health's mental health and wellbeing tracker, combined with digital and media analytics, demonstrates the positive impacts of the campaign, as well as important insights for continuing an integrated communication campaign.

- The Queensland Health Mental Health and Wellbeing Monitor 2020-21 Final Report indicates that reported mental resilience has decreased since the benchmark survey in 2019, with an observed deterioration in the initial COVID period of January to June 2020, which remained lower up to June and July 2021.
- Only 18 per cent of Queenslanders indicate high resilience and this remains an important area of focus for improvement.
- Various population subgroups are also showing shifts up and down:
    - Younger Queenslanders have lower resilience compared to older Queenslanders, although those middle-aged (35-64 years) have seen a decrease in resilience over the period.
    - Regional Queenslanders are becoming more mentally resilient, while at the same time there has been a decrease in resilience in metro areas, however, metro regions scored higher than regional areas in the benchmark.
    - There was also an increase in LGBTIQ+ Queenslanders with high resilience in the past year, despite experiencing more challenges than other groups during the initial pandemic phase. This increase means LGBTIQ+ people are almost back at the December 2019 benchmark level.
- Queensland should continue to invest in *Dear mind*—with ongoing refinement and delivery of the campaign for specific audiences—as an important and strategic contribution to enhancing positive mental health across Queensland.
- The Commission is collaborating with Queensland Health in the development of a reducing risky alcohol consumption campaign, which is currently in the planning stage.

Recommendation 23: Ensuring ongoing investment in strengthening individual understanding and action for positive mental health and wellbeing, for example through the *Dear mind* campaign and increase the cross-agency involvement in priority setting.

3.4 Aboriginal and Torres Strait Islander social and emotional wellbeing

- Aboriginal and Torres Strait Islander peoples adopt a holistic concept of social and emotional wellbeing that recognises the importance of connection to land, culture, spirituality, ancestry, family, and community, how such connections have been formed and shaped across generations, and the processes by which they affect individual wellbeing[194]. It further recognises the impact of policies and past events upon wellbeing[195][196].
- Aboriginal and Torres Strait Islander people continue to experience health inequities across diverse health and wellbeing indicators within the context of colonisation, historical and intergenerational trauma, impacts of the Stolen Generations and removal of children, systemic racism, discrimination, and social and economic disadvantage[197].
- Intergenerational trauma based on the consequences of colonisation and forced removal has been identified as a major contributor to First Nations peoples' experience of disadvantage and poor economic and social wellbeing, including the capacity to gain employment and earn an acceptable living.
- Aboriginal and Torres Strait Islander people experience a disproportionate burden of mental ill-health compared to non-Indigenous Australians. Over 32 per cent of First Nations adults responding to the National Aboriginal and Torres Strait Islander Health Survey (NATSIHS) in 2018–19 reported having a diagnosed mental health condition, with depression and anxiety the most prevalent conditions.

- The Productivity Commission (2020)[198] acknowledged that suicide rates among Aboriginal and Torres Strait Islander people are more than double that of other Australians, with young males and those in regional communities, particularly at risk.
- The Productivity Commission (2020)[199] also noted various socio-cultural determinants that uniquely influence mental health and social and emotional wellbeing outcomes for Aboriginal and Torres Strait Islander people in Australia[200]. More than 50 per cent of the differences in outcomes between Indigenous and non-Indigenous Australians is accounted for by social determinants of health.
- Aboriginal and Torres Strait Islander adults are almost three times more likely to experience high or very high levels of psychological distress than other Australians, are hospitalised for mental ill-health at almost twice the rate of non-Indigenous people and have twice the rate of suicide than that of other Australians.
- A recent review (2020) found that living in regional and remote areas was associated with a higher risk of suicide for Aboriginal and Torres Strait Islander youth, with young people aged under 25 years accounting for 41 per cent of all suspected suicides by Aboriginal and Torres Strait Islander Queenslanders in 2019. Those aged under 30 accounted for 60.7 per cent[201].
- Factors that are critical to, and enhance, the social and emotional wellbeing of Aboriginal and Torres Strait Islander people include connection to country, spirituality, ancestry and kinship networks, strong community governance and cultural continuity, renewal of culture and knowledge systems, and the capacity for self-determination[202 203 204].
- Holistic, healing-based approaches must be implemented that focus on the unique needs of families and communities where mental illness impacts, particularly relating to suicide, are experienced.
- The Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) Report and the Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention outline contributing factors and the unique impact of suicide in Aboriginal and Torres Strait Islander communities, as well as success factors identified by communities and those with lived experience. This includes the centrality of community leadership and connection to culture and Country.
- The ATSISPEP report further notes that cultural and lived experience leadership is critical because of the right of First Nations peoples to be involved in service design and delivery as mental health consumers, the likelihood of more effective and sustained outcomes. This aligns with Queensland's Local Thriving Communities (LTC) principles of local leadership and Queensland Health's Health Equity Reform.
- LTC is the Queensland Government's mechanism to implement the response to the Queensland Productivity Commission's (QPC) Inquiry into service delivery in remote and discrete Aboriginal and Torres Strait Islander Communities (QPC Report).
- LTC provides a clear, long-term, whole-of-government reform agenda to build government capacity to work with Queensland's Aboriginal and Torres Strait Islander communities, Councils, community leaders, and other stakeholders to co-design, implement, evaluate, and respond to community needs and priorities, and bring decision making closer to communities.
- Mental health is a critical priority for Queensland's First Nations communities and will be a key consideration for LTC Local Decision-Making Bodies (LDMB).
- To respond to such community needs, through LTC, the Queensland Government seeks to build on a community's strengths—embracing existing leadership structures, including Indigenous councils and community leaders—to enable LDMBs that will:
    - influence the co-design and delivery of services
    - ensure investment makes their community stronger, and

    - maximise opportunities from local service and industry partnerships.

- LTC aims to move away from top-down policy approaches that are less effective in promoting mental health and wellbeing, to community-led and strengths-based initiatives that nurture a sense of hope and empowerment and put power and decision-making in the hands of community leaders.
- Research also demonstrates that truth-telling and healing play a significant role in the overall mental wellbeing of First Nations peoples. The Queensland Government has committed to addressing these issues through the Path to Treaty process. Path to Treaty commenced in 2019 with the launch of the Tracks to Treaty and Statement of Commitment to a reframed relationship with First Nations peoples.
- Truth telling and healing are significant contributors to nurturing a sense of hope for First Nations Queenslanders. The opportunity to improve mental health and wellbeing through the Path to Treaty and related reforms that empower First Nations Queenslanders and celebrate their contribution to the State, are central to efforts to reframe the relationship.
- Following the initial work of an Eminent Panel and Treaty Working Group in 2019 and early 2020, a Treaty Advancement Committee was appointed in 2021 to undertake community engagement and consider the next steps on the Path to Treaty. Community briefings as part of this process emphasised the central role truth-telling and healing play on the Path to Treaty, which is supported in the research[205]. The Queensland Government is considering the Treaty Advancement Committee's report, including recommendations relating to truth-telling and healing and the next steps in the process.
- Findings from the *Changing attitudes, changing lives* research report noted that Aboriginal people and Torres Strait Islander people indicated racism and discrimination is one of the main issues impacting their social and emotional wellbeing and self-esteem and is a barrier to accessing services, treatment, and support[206].
- Aboriginal people and Torres Strait Islander people who have experienced discrimination also reported high or very high levels of psychological distress. The incidence of high or very high psychological distress among Aboriginal and Torres Strait Islander people (31 per cent) is over twice that of non-Indigenous people (14 per cent)[207].
- Another specific program of note under the broader LTC reform agenda is the Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships Social and Emotional Wellbeing (SEWB) Program[208]. The SEWB program supports specific co-design of initiatives to strengthen the social and emotional wellbeing of Aboriginal and Torres Strait Islander Queenslanders in line with the principles and objectives of the LTC. The SEWB program supports co-designed initiatives to improve mental health, respond to substance use issues, and reduce rates of suicide in Aboriginal and Torres Strait Islander communities.
- Programs are particularly focused on wellbeing in the early years, from conception to the first year of primary school, and youth mental health and suicide prevention.
- Investment to date is supporting Aboriginal and Torres Strait Islander communities with:
    - early learning and development
    - skills in emotional regulation and impulse control
    - community-led decision making on health priorities and suicide prevention strategies, and
    - upskilling community leaders to provide out-of-hours support for people at risk of suicide when other services are not available.
- This is an example of how LTC is reframing the relationship with Aboriginal people and Torres Strait Islander people—moving away from top-down government initiatives that hinder mental health and wellbeing, to community-led and strengths-based initiatives that are rooted in self-determination, culture, and healing.

- Furthermore, an approach to Alcohol Management Plans (AMPs) in remote and discrete Aboriginal and Torres Strait Islander communities across 15 Local Government Areas in Queensland has been introduced.
- The objective of the renewed approach to AMPs is to ensure communities and individuals are safe, thriving, and self-empowered to manage and reduce alcohol-related harm.
- The renewed approach is based on a partnership between the Queensland Government and communities to co-design new Community Safety Plans (CSPs) and other coordinated initiatives and strategies that reduce demand; target illicit alcohol (sly grog and homebrew); build community capacity and readiness; and promote a healthy culture and attitude towards alcohol.
- A key strategy within CSPs is investment into culturally safe and accessible mental health, social and emotional wellbeing, and alcohol and other drugs treatment services to support demand reduction.
- In August 2015, the National Aboriginal and Torres Strait Islander Leadership in Mental Health (NATSIMHL)[209] developed the Gayaa Dhuwi (Proud Spirit) Declaration for Aboriginal and Torres Strait Islander Leadership in Mental Health and Suicide Prevention.
- Queensland Health is implementing a First Nations Health Equity reform agenda to promote equity in service delivery, funding, and workforce composition, which should be seen as a best practice model to inform other service delivery reforms.
- Given the significant over-representation of Aboriginal and Torres Strait Islander people with mental health issues, Board representation of First Nations practitioners and people with lived experience is critical. This will assist in understanding the cumulative effects of intergenerational trauma and lived experiences of racism and discrimination.
- Effective mental health responses emphasise early identification and intervention, embed cultural capability into clinical practice, work across service types, including the community-controlled sector, focus on recovery, and integrate an understanding of trauma and trauma-informed care into services[210].

Recommendation 24: Embed the integration of Gayaa Dhuwi principles into policies, programs and services (across sectors and government agencies) to improve Aboriginal and Torres Strait Islander access to, and engagement with, the range of prevention, promotion and early intervention programs as well mental health and alcohol and other drug services.

Recommendation 25: Embed a holistic understanding of social and emotional wellbeing that centres on Aboriginal and Torres Strait Islander identity, values and needs across the mental health, alcohol and other drugs, and related systems and support culturally safe treatment, care and support.

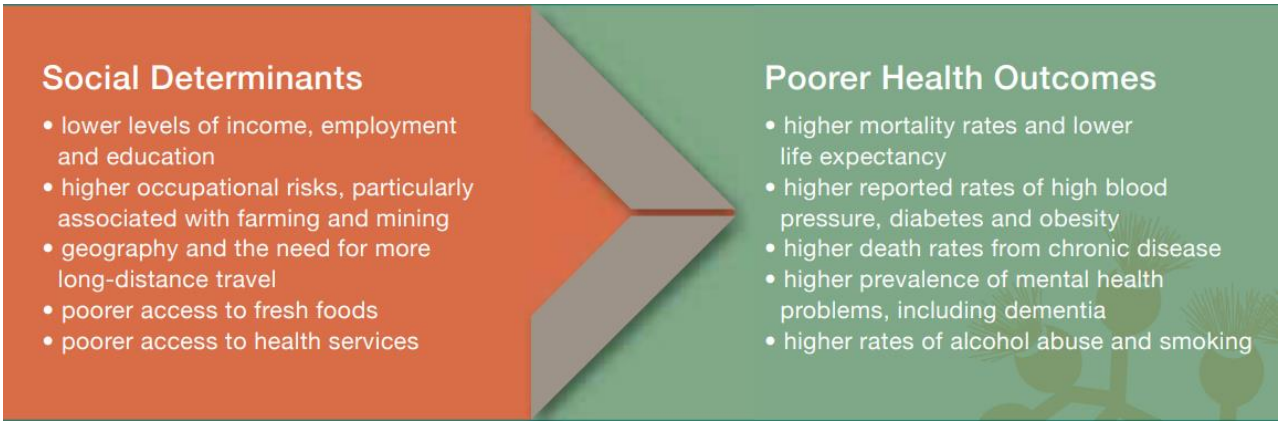
Recommendation 26: Consistent with the commitments under the National Close the Gap Agreement and the Productivity Commission (recommendation 23), preference the role of Aboriginal Community Controlled Organisations in the planning and delivery of mental health services, alcohol and other drugs services, suicide prevention, aftercare, and psychosocial support services, in line with the capacity of the service.

3.5 Supporting the mental health and wellbeing of people in rural and remote Queensland

- Queensland is the most decentralised state compared to other Australian jurisdictions[211]. Our regional, rural, and remote communities are great places to live, and each community is unique. A strong sense of community, resilience and support comprise some of the many benefits of living in regional, rural, and remote communities.

- However, there are issues of specific concern in these regions of the state. **Figure 13** provides an overview of the impacts of the social determinants on overall health status. Issues of concern include:
    - declining population growth due to outmigration of youth
    - limited educational and employment opportunities
    - economic uncertainty and instability
    - social and geographical isolation
    - limited and unreliable communication facilities
    - limited access to public transport
    - an ageing workforce, as well as workforce and skills shortages
    - the impact of natural disasters and mass adverse experiences, including drought, tropical cyclones and floods, bushfires, and most recently, the COVID-19 pandemic, and
    - downturns in service and business viability, including equitable access to healthcare[212,213].
- However, since the COVID-19 pandemic, migration to Queensland has increased, with a large proportion settling outside of southeast Queensland, which therefore may put pressure on regional health services.

Figure 13: Overview of the social determinants of health and health status of rural communities[214]



- While the prevalence of mental ill-health in regional and rural communities is similar to major centres, people in regional, rural, and remote communities face a higher incidence of suicide and hospitalisation due to self-harm, that increase with relative remoteness[215].
- It is estimated that suicide rates in rural and remote communities are approximately 40 per cent higher than in major capital cities, with farmers, young men, older people, and Aboriginal and Torres Strait Islander people in remote areas at greatest risk of suicide[216]. In addition, men living in rural and remote areas experience higher rates of psychological distress when compared to metropolitan areas[217].
- Critical issues facing the mental health and wellbeing of communities include:
    - the stigma associated with help-seeking behaviour
    - the need for evidence-based community education and awareness
    - strategies focusing on mental health promotion, prevention, and early intervention
    - a networked approach to the provision of adequate and integrated primary care through to tertiary care
    - growth, integration, and co-location of the community mental health workforce in primary settings

  - development of place-based, cross-sector and integrated models of care that have meaningful intersections stretching beyond the health sector—including justice, housing, disability, early childhood, aged care, education, and child safety
  - workforce and skills shortages (generalist and specialist, clinical and non-clinical), and
  - limited access to training opportunities[218,219].

- Regional, rural, and remote parts of Queensland face critical mental health resourcing issues to varying degrees, and the extent and impact of these is dependent on the funding and resources provided by state and Commonwealth Governments. This means that there are often workforce and specialist mental health-skills shortages in some regions while others are adequately resourced.
- There are a range of additional issues and barriers to accessing services for people living in regional and remote areas. These include the remoteness of some communities requiring people to travel long distances to access services, which can be exacerbated by a lack of community infrastructure such as public transport.
- Both telehealth and digital mental health solutions have been in use in Queensland previously and re-emerged during the COVID-19 pandemic as a solution to support health service delivery and reduce face-to-face contact. Tele-health solutions have been identified as solutions to the disparate access to care experienced by regional and remote communities. However, technological issues can impact the accessibility of tele-health services for people living in rural and remote areas and may not be appropriate in all circumstances. Tele-health services should not replace face-to-face treatment but should instead complement existing face-to-face services.
- The e-PIMH service, for example, is a telehealth-facilitated psychiatric consultancy service delivered to regional, rural, and remote sites in Queensland. It aims to support the mental health needs of parents, carers, and infants (aged 0-4 years) in the perinatal period by building local workforce capacity and providing telepsychiatry consultations. Expanding this model would see e-PIMH co-ordinators and navigators in the larger regional communities supporting and facilitating secondary consultations for identified rural and remote communities. An overarching State-wide Coordinator could provide leadership and support for the regional co-ordinators.
- There are also significant issues for health services recruiting to positions in rural and remote areas, particularly for specialists, and this can result in regional areas having high turnover rates in clinicians and/or long periods of unfilled positions.
- Stakeholders have called for governments to collectively develop a national plan to increase the number of practising psychiatrists, psychologists, and mental health nurses in the regions where they are needed most. This must be supported by increasing the availability of supervision for trainees, with a focus on sub-specialties and localities where there are substantial shortfalls.
- Most people who are in a mental health crisis or who are experiencing distress do not need to see a psychiatrist and may instead require the support of a clinician with specific mental health training and experience. There are opportunities to enhance the availability of nurses and nurse practitioners with specific mental health training and experience as an option to fill this service gap.
- For Aboriginal and Torres Strait Islander peoples, there are calls to enhance the understanding of social, emotional, and cultural wellbeing as distinct from mental health., Services should recognise this distinction and give consideration to expanding accessibility and availability of trained Aboriginal and Torres Strait Islander health workers.
- There are also opportunities to enhance existing infrastructure and local networks to better support people who are in distress, beyond a purely health system response. This may include enhancing existing community responses through neighbourhood centres to support people who are in crisis, without necessarily requiring a clinical response.

- Social and cultural barriers can also affect the level of understanding service providers have about local cultural issues and make it difficult for clients to build trusting relationships. This includes issues such as perceived stigma, a feared loss of privacy and confidentiality in small communities and impacts from the turnover of mental health workers.
- Beyond general measures to strengthen the mental health workforce, there are opportunities to enhance the integration, coordination, and funding of services between Commonwealth, state, and regional agencies to better integrate existing services. There are opportunities for all levels of government to collaborate on the planning, commissioning, implementation, and evaluation of services to deliver more targeted and effective services.

Recommendation 27: Augment and expand the range of culturally appropriate, complementary online mental health, suicide prevention and primary mental health programs and services including online assessment and referral platforms, online psychiatric assistance for GPs, and clinician-supported online treatment.

Recommendation 28: Work towards the delivery of a comprehensive range of mental health, suicide prevention and primary health programs for First Nations communities including, services delivered by Aboriginal Community Controlled Health Services.

Recommendation 29: Government should incentivise mental health-related university education, including supervised work placements, in rural, regional, and remote Queensland–similar to the requirements for some medical professions–to increase the future mental health workforce in localities with substantial shortfalls.

Recommendation 30: Government agencies should work with local and relevant Queensland-based stakeholders to improve culturally safe mental health services and supports to people in rural, regional and remote Queensland, and support Aboriginal Community Controlled Health Services to deliver mental health, suicide prevention and other primary health programs and services where appropriate, to complement mainstream services.

Recommendation 31: Implement a range of strategies to address workforce shortages in rural and regional areas, including workforce management approaches that

- enable the sharing of human resources to fill critical workforce gaps across rural areas,
- support ongoing development and optimisation of generalist workforces including opportunities for expanded scope of practice for some professions and roles
- provide incentives that address holistic personal as well as professional needs including renumeration, employment arrangements and practice support, and
- support online professional development opportunities and communities of practice.

Recommendation 32: Strengthen cooperation between Primary Health Networks (PHNs) and Hospital and Health Services (HHS's) by requiring comprehensive joint regional planning, co-commissioning and formalised consumer and carer involvement.

Recommendation 33: Develop service responses that respond to the needs of rural and regional families including expansion of e-PIMH Network

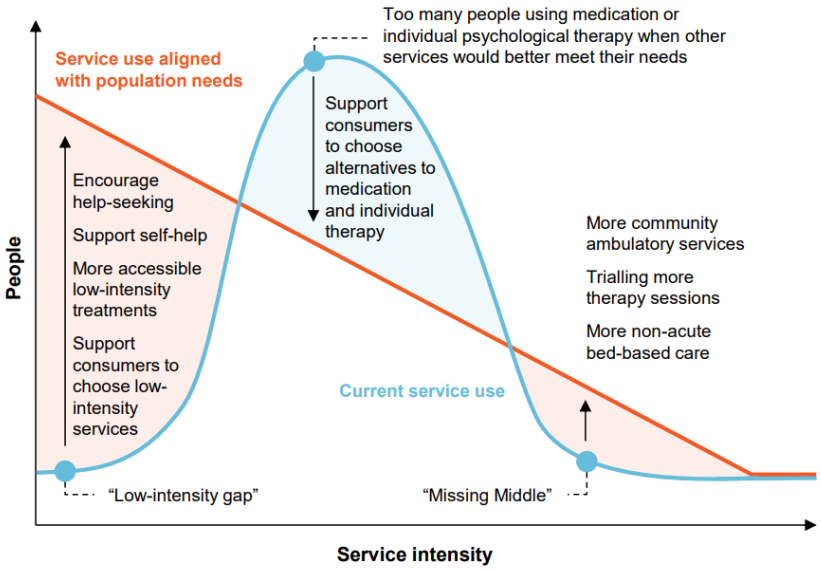
3.6 People at the centre: build a responsive and integrated community-based system

The need for a reoriented and responsive approach

- Over the years, successive state and national governments have identified the overarching goal of providing quality mental health treatment, care, and support, when and where it will benefit most.
- While many Queenslanders access the support they require, consumers, their families, carers, and support persons continue to report challenges in finding an entry point, navigating a patchwork of services, or experiencing inadequate or inappropriate responses to their needs.
- The many factors that contribute to this situation have been discussed in this Submission and documented by others. The result is deficiencies in the continuum of care, with vital missing services or service elements depending on where a person lives, their primary need, and level of need.
- The onus is frequently on the person, their families, carers, or support people to navigate a highly complex landscape to seek the appropriate clinical and non-clinical supports they require[220].
- This also serves to increase pressure on the broader workforce, including general practitioners, teachers, housing support workers, and social workers, for example, to provide support and direction.
- The resulting crisis-driven response has led to the rationing of services, resulting in raised thresholds for service access. This is particularly evident in the public mental health service system where services mostly treat people who are most unwell or most at risk, and where treatment cannot be delayed any longer[221].
- The current mental health service system primarily offers support at the two ends of the needs spectrum.
- Primary and private healthcare services provided by general practitioners and other allied health professionals are designed to support people with mild to moderate needs, while the public mental health system is designed to support people with severe mental health conditions.
- Neither of these service components can meet the current needs within their area of responsibility, with two critical gaps in Australia's healthcare system identifiable: the low-intensity gap and the missing middle. Nationally, it is estimated that:
    - up to 500,000 people are not accessing any mental healthcare, but could benefit from low-intensity services
    - up to one million people living with mental ill-health, and approximately 5.9 million Australians at risk of developing mental ill-health, are not accessing any services, and
    - about 40 per cent or two million people out of a total of nearly five million Australians who use psychological, or pharmacotherapies could further benefit from low intensity supports, that would result in less cost, less time consumed and potentially fewer adverse side-effects[222].

- **Figure 14** provides an overview of the low-intensity gap, the missing middle and the need to align services with population need and intensity[223].

Figure 14: The low-intensity gap and the missing middle[224]



- Service gaps are further pronounced for people whose mental health needs are too severe, complex, and enduring to be adequately supported through primary healthcare services but considered too severe to meet the clinical threshold for public specialist mental healthcare services—often referred to as the *missing middle.*
- Few options are available to people who do not meet the threshold to access specialist mental health and alcohol and other drugs services, with limited progress in developing appropriate service responses for people with mild to moderate, and moderate to severe needs.
- By failing to provide support early to people who do not meet the current threshold and/or capacity of the public mental health system, vital opportunities are missed to improve individual outcomes, as well as stop escalation and progression to tertiary and crisis services.
- This issue is particularly experienced by specific populations who experience a range of barriers to accessing and utilising services, including:
    - children and young people, including children and young people engaged with the child protection and youth justice systems
    - Aboriginal and Torres Strait Islander Queenslanders
    - people from cultural and linguistically diverse backgrounds, including asylum seekers and refugees
    - people living in regional, rural, and remote communities
    - people living with a disability
    - people from low socio-economic backgrounds, and
    - people engaged with the criminal justice system[225].
- This growing service gap is not unique to Queensland and presents a significant challenge nationally.
- This challenge further reflects continuing over-reliance on clinical and treatment pathways, as responses to what may primarily be psychosocial challenges, better serviced through non-clinical responses.
- The undersupply of community-based mental health services limits important potential for responding early, preventing illness progression, and supporting adjustment and/or recovery.
- Such service gaps are a driver of increased presentations to the emergency department. This means that "several hundred thousand people are only receiving a fraction of the care they need

or are missing out on community ambulatory care altogether"—significantly impacting their quality-of-life outcomes[226].

- High demand on emergency departments further means that people may experience lengthy delays in assessment and treatment, particularly if inpatient care is required[227]. In addition, emergency departments can be inappropriate, unsuitable, or harmful environments for people experiencing significant distress[228].
- The current demand for crisis care and support could be reduced by adequate and appropriate resourcing at the non-acute/middle level of healthcare. Adequate and commensurate resourcing at this level, including providing low-intensity supports, would enable support to people whose needs cannot be solely supported through primary healthcare, but who also miss out on more clinical, community and hospital-based mental health healthcare and support, due to high demand[229].
- Treatment and support available outside of the hospital environment, for example, peer and clinician-led, provided after-hours or through mobile teams, would better support needs, stem the escalation to acuity and reduce pressure on more costly systems. However, treatment, care and support must be age, developmentally and culturally tailored.

Reorienting towards the community

- People with lived experience, their families, carers, and support people have consistently told the Commission that they seek a mental health system that enables:
    - access and navigational support to timely, quality, and appropriate treatment, clinical and non-clinical care and supports across the spectrum of severity
    - a system and services that promote inclusion—as opposed to exclusion—and address the broad factors that prevent access to a flourishing and prosperous life
    - access to community-based supports when required and where they will benefit most, supported by commensurate inpatient care and community residential services when required, and
    - access to evidence-based, trauma-informed, culturally appropriate, and person-led psychological, pharmacological, and psychosocial interventions, where the person, their families, carers, and support are placed at the centre.
- A significant proportion of the mental health system is traditionally planned around clinical interventions that focus on symptom reduction. However, the impacts and experiences of mental ill-health, vulnerability, distress and problematic alcohol and other drugs use are highly individual, and dynamic[230].
- The overarching system must evolve to ensure that such responses better meet whole-of-person needs. This means that a person, their family, carers, and support people should be able to access the mix of services that correspond with and are conducive to their needs and preferences, and not be refused treatment, care and support due to 'not being sick enough' or 'not meeting criteria'.
- Funding mechanisms are a key lever for service capacity and improvement. However, such mechanisms need informed through population needs-based planning to ensure appropriate service system mix and design.
- Just as important are the connections and transition points across service elements, to ensure continuity of care and holistic person-centred responses.
- While the necessary reforms are transformational to lives and systems, this must be built on and supported through foundational and integrated reforms across all areas of governance, funding, system planning, monitoring and evaluation.
- Each of these vital ingredients of a person-centred and effective mental health system currently occur in as fragmented a manner as the system that is delivered.

- For any service enhancement to meet its desired individual and system change outcomes, shared system leadership and accountability must be strengthened through integrated governance arrangements focused on service planning, shared priorities, and resources.
- Effective responses to meet the mental health and wellbeing needs of Queenslanders, contributing to whole-of-person, quality-of-life outcomes requires the clear integration and coordination of a comprehensive range of hospital-based care, community clinical treatments, community-based psychosocial support, primary healthcare, and non-clinical systems and services, including housing, employment, and education[231].
- While based in the community, it will need to be complemented by treatment, care, and support through, for example, hospital and other residential services. This design reflects national and international evidence that supports a balanced system design that covers community-based services and inpatient care[232].

Responding to complexity—models that support holistic care

- Designing services that are adequately equipped to respond to morbidities or 'multiple-morbidities', such as co-occurring mental health, alcohol and other drugs, disability, and chronic health conditions, increases the importance of service systems to be well-integrated to provide suitable care.
- Integration can occur at the system level or service level—ideally both.
- Systems integration involves combining policy, funding, and administration of services. Service integration endeavours to integrate different types of services such as alcohol and other drugs and mental health, or homelessness services and mental health, for example[233]. The aim is to provide a service that can address multiple service needs and that facilitates greater system efficiently by minimising duplication.
- Service level integration can ease issues such as information sharing, collaboration, and client pathways, but can also accentuate other issues such as clinical governance and can reduce specialisation of services.
- There are several models that support holistic care, such as care coordination partnerships; co-location of services; specialist dual diagnosis services; multidisciplinary teams and secondary consultation models[234].
- System integration beyond the health system is needed, as the likelihood that a person experiencing a mental illness will also experience a physical health, substance use or other co-morbidity, as well as impacts in other areas, such as economic participation and housing.
- System integration requires robust governance mechanisms to support this systemic shift, as well as to ensure quality and safety are maintained.
- A responsive, integrated system is not based on diagnostic or other criteria. It is a system that is accessible to people where and when they are seeking support; and has an accessible entry point that also facilities continuity of care they access different parts of the system to support their recovery.
- A move away from diagnostic dependent or severity inclusion criteria is increasingly accepted as an important element of a responsive system.

A new community-based front door

- The recent Commonwealth Government investment into Head to Health centres can drive the establishment of new community-based infrastructure and should function as an integrated front door for a range of mental health and wellbeing needs.
- Consistent with the recommendations of the Royal Commission (2021)[235] a community-based mental health and wellbeing system is one that reorients the current approach towards

community-based support and should define the future of treatment, care and support that is provided outside of the hospital environment.

- This approach recognises the importance of the social and relational context of people's lives and seeks to ensure that support is provided within the home, or as close as possible to families, communities, social networks, and connections. Therefore, services need to be provided when and where they will benefit the person, and their supports most. These are critical elements to supporting recovery and promoting healing.
- Through a co-planned approach, community-based mental health and wellbeing services should match population needs within the specific catchment region and be designed to provide a highly accessible, inclusive, and soft entry point to mental health and alcohol and other drugs assessment, engagement, treatment, support, and care.
- Community-based mental health and wellbeing services should be a genuine alternative to hospitalisation, and should not have an exclusionary, threshold, or criteria-based approach to accessing mental health and wellbeing services. This seeks to ensure that all people, whether they are vulnerable, in distress or in crisis, can access the appropriate supports regardless of whether they are eligible for public or primary healthcare.
- This approach further recognises that there are many settings and services that provide mental health and wellbeing support. This includes universal community and social settings and infrastructure, such as schools and housing services, for example, as well as specialist supports, including bed-based or emergency mental health services.
- In keeping with directions increasingly adopted in other jurisdictions, it is recommended that a community-based approach is developed to best respond to the differing needs across the life span.
- This requires consideration of service design that delivers developmentally integrated responses across the distinct infant, child and youth mental health and wellbeing stream (0-11 years and 12-25 years); and an adult and older adult mental health and wellbeing stream (26+ years).
- The design and establishment of services needs to be effectively integrated into the broader service system, with clear linkages between primary and secondary care, as well as bed-based care for persons who require higher intensity care.
- Service integration in this sense goes well beyond co-location or coordination of services to a common client. Truly integrated services depend on specific organisational, practice, workforce, and leadership prerequisites. Integration must be embedded in the model of service, procedures, information management, and quality, as well as the supervision and training of providers.
- Core services that could be provided include:
    - support and advice to access a range of mental health and alcohol and other drugs services
    - central intake and assessment, including identification of the range of social, cultural, health, education and employment needs associated with mental health and alcohol and other drugs ill-health
    - provision of evidence-based treatments to commence recovery, including while waiting to be connected to longer term or more appropriate follow-up care, and to facilitate access to other services or information, including online interventions.
    - immediate support to reduce distress for people experiencing crisis or who are at risk of suicide, including proactive aftercare support
    - extended opening hours or hours of operation outside standard business hours, and
    - lived experience workforce.
- These services should seek to provide a comprehensive range of supports that are delivered through a range of community-based approaches, including:

  - co-location of multi-disciplinary, site-based services
    - digital mental health and telehealth approaches
    - crisis outreach services
    - hospital in-the-home services
    - home and community-based visits, and
    - assertive outreach for persons with high and complex needs

- Delivery of treatment, care and support through diverse models and approaches is critical, as this enables the person more flexibility in how they are supported, and is responsive to their social context, strengths, and circumstances.
- However, the predominant mode of delivery for most services will be through the provision of site-based care, whether this be through for example, a mental health service, multi-service centre or other locations where such services are provided. This enables these sites to become hubs of activity and community within the broader mental health and wellbeing system.
- The suggested approach needs to be grounded within primary and secondary care; therefore, the strengthening and integration of primary and secondary care is critical.
- Similar to the Trieste model of community mental health care[236], each centre should cover a population of 50,000-70,000 people. In addition, each centre should provide a hub-and-spoke model to cover smaller communities across Queensland, operate extended hours, including weekends, and be a service point for first responders.
- The Victorian Government, in collaboration with the Commonwealth Government, is rolling out a similar model of 60 of adult community centres across Victoria in response to the recommendations of the Royal Commission into Victoria's Mental Health System (2021)[237] .
- It is recommended that public mental health clinicians are co-located within the new centres, however as required, they should minimise their case management role and primarily provide a range of treatment and interventions. This also supports people to maintain their mental health and wellbeing in the community, as close to home and to support persons as possible; and would provide people discharged from hospital with appropriate follow-up and community-based support and treatment.
- The role of public inpatient mental health services should continue to target people at the acute phase of mental illness and alcohol and other drugs use, that requires hospital admission. The gateway into acute hospital bed-based services should be primarily through the new community centres or an alternative to the emergency department, such as the service currently being trialled at the Gold Coast.
- It is important to recognise that developing the new 'front door' to mental health services, will require fundamental enablers such as workforce availability, funding arrangements, lived-experience engagement, and governance, with broad agreement across all stakeholders. Key elements associated with this model of care include:
  - Ease of accessibility to culturally responsive, trauma-informed, and person-centred services for individuals and families that are low stigma, emphasising a 'no wrong door' response to people needing to access services.
  - The available workforce to deliver evidence-based, high quality and safe assessment, interventions, holistic supports, and ongoing follow-up and care.
  - Continuity of care that seamlessly connects individuals to supports through integration with existing mental health and alcohol and other drugs services across the continuum. Continuity of care is dependent on connectivity with other supports and services enabled by co-location, jointly developed care plans, shared information systems, common outcome measures, joint workforce training and support, and mutual governance frameworks. Consideration of the existing service landscape within a community is required to prevent duplication and ensure clarity of referral pathways.

- The workforce providing this model of care must be capable of meeting the holistic needs of individuals and address the social determinants of mental ill-health; and able to support access to the range of social and human services required by an individual and/or their family.
- Flexible modes of service delivery, incorporating technology and online formats, as well as the ability to escalate service responses up or down as an individual's needs or illness changes. Seamless pathways to clinical treatment services, including community mental health and bed-based treatments must be available and supported by strong connections with existing public mental health services.

Recommendation 34: Shift towards a community-focussed mental health and wellbeing system that establishes a community-based infrastructure which integrates public, private and NGO services to provide a new and broader front door for people experiencing mental health problems across the spectrum of need.

Specific focus on child and youth mental health

- A critical need has been identified in child and youth mental health treatment across the spectrum of mild-moderate to severe conditions.
- The mental health and wellbeing of children and young people has been significantly impacted by the COVID-19 pandemic, which has resulted in an increased demand for child and youth mental health treatment services.
- Specific demographic groups of children and young people require specific mental health intervention and support from a highly skilled child and youth mental health workforce. Examples of these groups are:
  - children and young people in out of home care, and
  - young people involved in the youth justice system.

Children and young people in out of home care

- Children and young people in out of home care, including residential care, group homes and kinship care, have high rates of adverse childhood experiences.
- Emotional abuse (54 per cent) was the most common type of abuse or neglect substantiated through child protection investigations in 2019–20 in Australia. This was followed by neglect (22 per cent), physical abuse (14 per cent), and sexual abuse (9 per cent)[238].
- Queensland has specific child and youth mental health services for children subject to statutory care with the Department of Children, Youth Justice and Multicultural Affairs. This specific service is Evolve Therapeutic Services (Evolve), within Child and Youth Mental Health Services (CYMHS), and delivered by the public mental health system up until the age of 18 years
- This service type works with the foster carers and long-term guardianship carers on mental health and behavioural strategies from a developmental, trauma and attachment informed approach, which suits provides children and young people with some stability such as those on long-term guardianship orders with some stability, and a consistent carer-giver figure.
- This service model is less suitable for young people where there is a higher degree of instability and mobility, such as in cases where the young person is self-placing or living in out of home care in a group home setting environment that has a high degree of instability or volatility. These factors can mean an appointment-based service such as Evolve do not necessarily match the needs of the young person.
- Other public child and youth mental health services dedicated to working with cohorts of young people who meet the criteria of a severe and complex menta illness include outreach models

such as AMYOS (Assertive Mobile Youth Outreach service) and intensive models such as Adolescent Day Programs. AMYOS provides a mobile outpatient service and intensive case management for young people with severe and complex mental illness who are unable or unwilling to engage in mental health treatment in an appointment-based clinic setting. This service has some after-hours capacity.

- These services are only accessible by young people who are currently CYMHS clients and have limited to metropolitan and some regional areas. They are not accessible in rural or remote areas.
- Adolescent Mental Health Extended Treatment Initiatives (AMHETI) are extended treatment and rehabilitation mental health services for adolescents with severe, complex, and persistent mental illness. These service types include AMYOS, Youth Residential Rehabilitation Units, Step Up/Step Down (SUSDU), acute inpatient units and the state-wide sub-acute unit Jacaranda Place. The Step Up/Step Down units are a joint organisational model across non-government and HHS service providers.
- The target cohort for these services is aged 13 to 18 years, however the Youth Residential Rehabilitation Units and Step Up/Step Down units also accommodate 16–21 years of age.
- There is a need for greater transitional support for young people with severe and complex mental illness transitioning from child and youth services to adult mental health services at the age of 18 Adult services operate from a clinical framework with less of a developmental, attachment and family focus than child and youth services.

Recommendation 35: Improve the continuity of care through enhanced transitional planning across service delivery for children and young people.

Youth justice involved young people

- The Australian Institute of Health and Welfare's *National data on the health of justice-involved young people: a feasibility study 2016-17*[239] reported:
  - rates of psychosis among youth in detention are 10 times those in the general community
  - one quarter of those in youth detention who had ever had thoughts of suicide or self-harm reported an increase in those thoughts after entering custody
  - the rates of mental health diagnosis and suicidal behaviour rise with an increase in youth justice supervision, with higher rates for those in detention than those in the general population, and
  - despite high levels of need, mental health service use is often low in this group, particularly when released back to the general population.
- Provision of targeted evidence-based interventions are required for young people at any stage of involvement with the justice system. Understanding and addressing the causes of, and contributors to offending behaviour in individuals and cohorts, will maximise the prospect of behaviour change and improve life outcomes. This includes considering and addressing neuro developmental, cognitive, personality, cultural, age and maturity factors.
- Understanding the pervasive role of trauma in contributing to offending behaviour and ability to comply with sanctions and orders, is critical. Trauma, abuse, and neglect impair development in crucial areas of impulse control and self-regulation, and result in increased hyper-vigilance, impulsivity and difficulty trusting others, reduced resilience, and other factors known to increase the risk of offending.
- Trauma-informed approaches are required at all points of contact with the youth justice system and all relevant workforces require trauma-informed competency.
- The social and economic circumstances of vulnerable young people should be identified and addressed early, including family functioning, educational needs and school engagement, alcohol

and drug issues, trauma, homelessness, and economic disadvantage. Family-based intervention reduces risk of offending behaviour and its continuation. Family and community approaches are particularly critical for Aboriginal and Torres Strait Islander young people.

- Culturally appropriate and safe supports are required to support the mental and social and emotional wellbeing of the young offender and their family with a focus on rehabilitation and healing.
- Aligned with *Working Together, Changing the Story*, continuing and strengthened efforts are required to prevent and intervene early before offending occurs.
- A strong association exists between Adverse Childhood Experiences and offending behaviour, including experiences of abuse or neglect, educational exclusion and disengagement, poverty, economic and social disadvantage, domestic violence, homelessness, alcohol and drug issues, disabilities, and health and mental health concerns, including mental health problems.
- The continuation of social, educational, and vocational engagement and participation are important protective and rehabilitative factors that should not be undervalued.

Multi-agency responses to complexity

- Targeted, specialist and multi-agency interventions are required that respond to individual needs if the significant individual, social and system impacts are to be reduced. Interventions must be available to respond to trauma and mental health challenges, problematic alcohol and other drugs use, neuro-developmental challenges, learning and other educational difficulties, family problems and economic hardships.
- Examples of multi-agency responses for young people with multiple complex needs including mental concerns, substance use issues and involvement with child safety and justice include:
    - SMART (Specialist multi-agency response teams) that are located in several sites across Queensland, including Brisbane and Townsville. The SMART teams work together across government agencies and with non-government organisations.
    - The co-ordinated care for vulnerable young people panel (CCYP) that operates in Cairns, is a collaborative care model with a coordinated response across sectors for young people who are falling through the cracks in different systems such as disability, child safety, youth justice, education, mental health, and alcohol and other drugs.
- There is significant potential to better organise policy and resources around the pathways of young people with mental health needs who come into contact with multiple services. These young people face life challenges that are complex and interrelated, but system responses are siloed and perpetuate mental ill-health within cycles of disadvantage.
- Integrated policy, program, and service responses across the key agencies relevant to children and young people—and in particular those with experience of trauma and adversity—needs to be established as the standard approach.
- On an average day in Queensland, approximately 52 per cent of young people involved with youth justice services were completely disengaged from education, employment, and training. In addition, 58 per cent had a diagnosed or suspected mental health or behavioural disorder[240].
- Disengagement from education is a significant risk factor for offending behaviour and for developing substance use problems [241]. An exclusion or cancellation of enrolment from a primary or secondary school can result in a significant disruption and can have a negative impact on the trajectory of a child or young person.
- There are some youth service models that operate across education and mental health, such as the Ed-LinQ model. Previous cross-agency models that have operated in Queensland have assisted in supporting school engagement but have faced a range of challenges in practice such as information-sharing, appetite for risk, and duty of care across agencies.

Age of criminal responsibility

- Consideration of the minimum age of criminal responsibility is currently generating debate in the community with strongly held points of view. This issue, while complex, cannot be separated from consideration of ways to improve mental health and wellbeing outcomes for children and young people—particularly already vulnerable cohorts.
- The minimum age of criminal responsibility across Australian jurisdictions is currently 10 years of age.
- At the Meeting of Attorneys-General on 12 November 2021, the development of a proposal to increase the minimum age of criminal responsibility from 10 to 12 years was supported.
- In his 2018 Report on youth justice, former Commissioner of Police, Bob Atkinson AO APM recommended that the Queensland Government advocate for national consideration of increasing the minimum age of criminal responsibility with the aim of achieving a uniform approach between the States and Territories, subject to national agreement.
- Due to the range of systemic implications, a fulsome analysis is required of the individual, service, and community impacts, intended and unintended, of any change to the minimum age of criminal responsibility. This includes consideration of the program and services responses that will be required because of changes in direction.

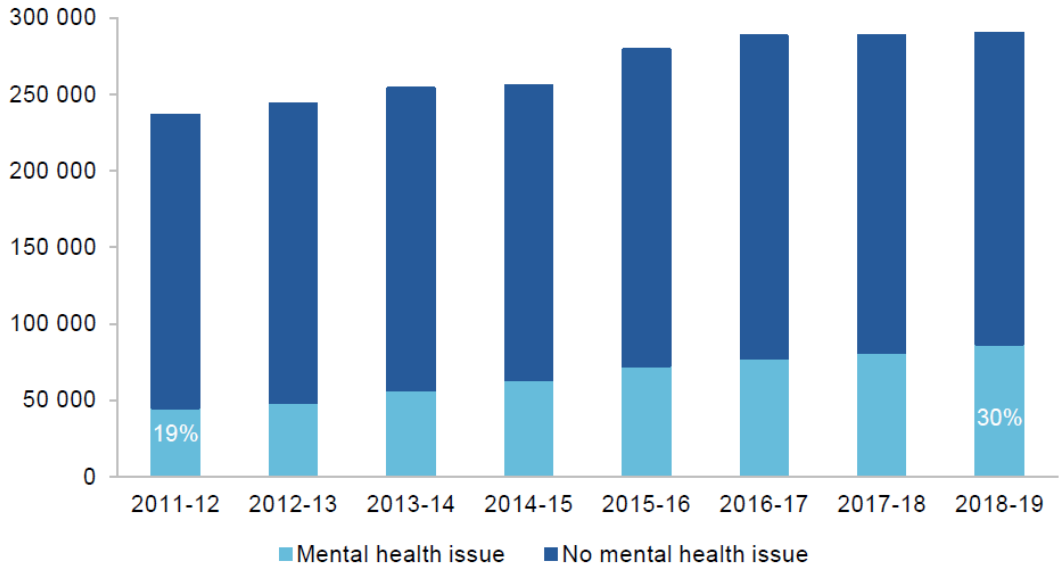
3.7 Importance of key non-health supports

Housing and homelessness

- Access to safe, secure, and affordable housing is a significant contributing factor to keeping people well, preventing mental ill-health and promoting long-term recovery. The relationship between housing, homelessness, mental illness and problematic alcohol and other drugs use is strongly interrelated, highly complex and bi-directional[242].
- Access to safe and secure housing facilitates social inclusion, treatment and recovery, and the delivery of support services. Without a home, it is more challenging to deliver effective community-based support, more demanding to self-manage care and treatment plans, and more difficult to establish relationships with treatment and support teams.
- However, access to secure, affordable, and appropriate housing remain under increasing and sustained pressure due to several factors. This includes:
    - the changing nature of housing demand
    - the escalating cost of homeownership
    - increasing and widespread housing stress
    - social housing shortages and growing demand for social housing, mostly comprised of applicants in greatest need
    - insecure private rental tenure, and
    - increasing levels of homelessness[243].
- Queensland has experienced a significant reduction in the availability of affordable housing properties, with regional Queensland significantly impacted with vacancy rates under 1 per cent in most regional towns. This has severely impacted the availability of affordable housing options for people with lived experience of mental ill-health, problematic alcohol and other drugs use, and at risk of homelessness[244].
- People with lived experience of mental illness and problematic alcohol and other drugs use have greater housing instability, poorer housing quality, variability in housing pathways, less choice of living conditions and neighbourhood amenities, and are highly vulnerable to homelessness. Solid and compelling evidence demonstrates that mental ill-health contributes to financial hardship and forced moves.

- According to Brackertz et al (2021), the experience of psychological distress increased the likelihood of financial hardship in the following year by 89 per cent and the experience of financial hardship in two years by 96 per cent[245].
- In addition, comorbid physical and mental health issues can undermine the ability to maintain and sustain a home, further impacting security of tenure. It is well-evidenced that housing choice and control over housing and support are fundamental contributors to quality-of-life outcomes for people with mental ill-health[246]. This includes fostering greater wellbeing, meaningful social connections, and decreased symptoms and service use[247].
- Mental ill-health may prompt or precipitate homelessness[248]. Figure 15 provides an overview of the growing number of people accessing specialist homelessness services, by mental health status since 2011-12[249]. Nationally:
    - Specialist homeless service (SHS) clients living with a current mental health issue comprised 32 per cent of all SHS clients in 2020-21, a significant increase from 19 per cent reported in 2011-12[250], and
    - the total number of SHS clients who received support from SHS agencies increased on average by 7.8 per cent from 2011-12 to 2020-21. This increase was approximately four times faster than for all SHS clients in general (1.8 per cent)[251].

Figure 15: number of persons accessing homelessness services by mental health status[252]



- In 2020-21, over 11,635 Queenslanders with current mental health issues received support from a specialist homelessness service[253]. In the year before accessing support, SHS clients were significant users of non-homelessness services, including health, justice, emergency, and welfare services, compared with the broader Australian population[254]. The rate of mental health issues is substantially higher among people with a history of homelessness (54 per cent) when compared to the general population (19 per cent)[255].
- The findings of Brackertz, Davidson and Wilkinson (2019)[256] identified several service gaps that contribute to inadequate housing and may further exacerbate mental health issues for people with lived experience of mental ill-health. These include:
    - access to available housing and mental health supports in specific locations, an issue further compounded in rural and remote areas
    - inadequate supply of affordable and appropriate housing
    - underdeveloped discharge planning for people exiting hospitals or other facilities
    - insufficient integration between housing and mental health services

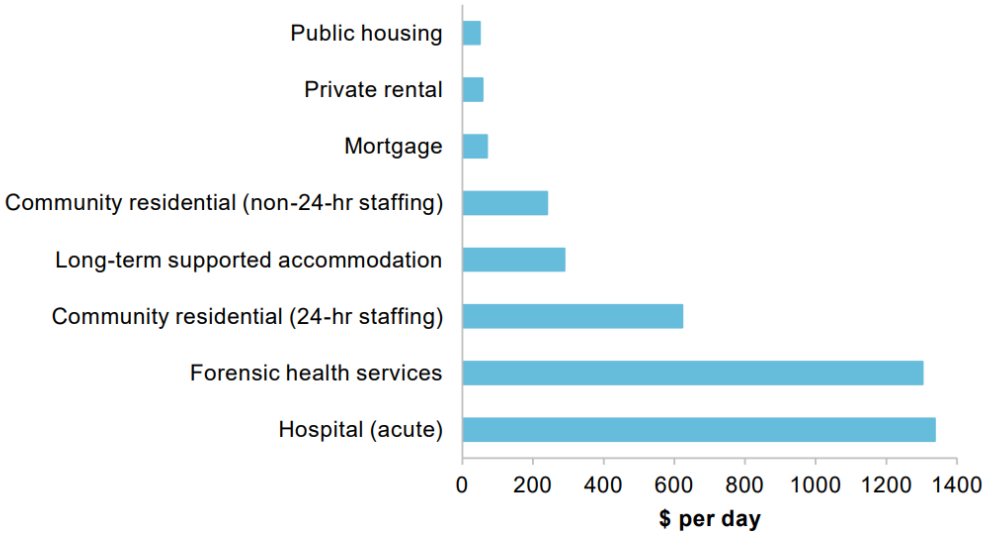
  - rationing of housing or mental health services due to high entry thresholds, and
  - barriers to collaboration and service integration, including information collection and sharing.

- People with mental ill-health or problematic alcohol and other drugs use are particularly vulnerable to experiencing homelessness[257]. People with lived experience of homelessness and mental ill-health represent a hard-to-reach group for service providers[258]. In an analysis of the 500 Lives 500 Homes Registry, fortnight homelessness data in the Brisbane Local Government Area[259] (2016) identified that were four categories of people living with severe mental illness and experiencing homelessness, including:
  - people who are homeless and not in receipt of services to support their mental health issues
  - people who are attended to and hospitalised but not adequately supported when discharged
  - people who being treated in a psychiatric facility in hospital who remain hospitalised because there is no discharge or exit strategy, and
  - people who experience primary or secondary homelessness who reside in substandard and insecure tenures and may be experiencing challenges in managing their mental health condition.
- It is well evidenced that the environmental stress associated with the experience of housing instability or homelessness can trigger, exacerbate, or magnify mental health issues[260261262]. People experiencing homelessness with mental health issues require the support of various services. Navigating these services can be particularly challenging, and adequate support from homelessness and mental health services is critical for finding and retaining housing[263].
- The effects of homelessness can be far-reaching, affecting adults, families, children, and young people. For people experiencing mental ill-health, it is difficult to access and navigate both housing and mental health systems without appropriate support; and they are often required to balance their mental health needs and their housing needs[264].
- Supporting the needs of people with lived experience of mental ill-health or problematic alcohol and other drugs use, who are currently homeless or at-risk of homelessness, requires an integrated approach. This includes:
  - increasing the availability of safe, secure, appropriate, and affordable housing
  - providing more and better support to sustain tenancies, and
  - strengthening and expanding early intervention and prevention[265].
- It is well established that Housing First models effectively combat homelessness and improve the mental health and wellbeing of people experiencing persistent homelessness. However, despite such efficacy, Housing First models are limited due to the lack of appropriate, affordable housing supply required to provide long term housing solutions to persons experiencing homelessness[266].
- An evaluation of the Brisbane Common Ground[267] , a housing-first model that provides permanent supportive Housing and intensive and integrated support for people with complex needs, found that a previously homeless person saved the community $13,100 per year per person in reduced service usage. This housing first approach resulted in a 65 per cent reduction in episodes requiring mental health services[268].
- A growing body of evidence has demonstrated that integrated approaches to addressing housing and mental health needs are highly effective but cannot meet the increasing demand for services[269]. There is extensive evidence of diverse models that successfully deliver person-centred and recovery-oriented housing. However, such models cannot meet the current and growing demand, requiring consideration to consolidate what works, scale-up, and expand programs to meet current and future demand[270]. While there is no one-size-fits-all approach, certain elements and principles are evidenced to facilitate positive outcomes. These include:

- access to affordable, appropriate, and stable housing
- policy and stakeholder coordination
- integrated, person-centred support with seamless wrap-around service delivery, and
- provision of programs to support diverse needs[271].

- The Productivity Commission (2020)[272] found that housing and mental health supports that enable people to live in the community "can also be cost-effective where they help people avoid spending time in relatively higher cost acute settings, such as residential mental healthcare or hospitals". This would make hospital beds available for people who require them and reduce a large percentage of bed blocking in the current system (**Figure 16**).
- With this, discharge from hospitals and mental health services presents a significant risk for homelessness[273]. Various jurisdictional surveys have suggested that 30 per cent of admitted patients in psychiatric wards (about 2000 people or 650,000 inpatient bed days) could be discharged if appropriate housing and clinical and psychosocial community services were available[274]. The Productivity Commission (2020)[275] concluded that "for each individual retained in an acute hospital bed, who could be treated (at least as well) in a non-acute bed-based service, the health system is overspending"[276].

Figure 16: Average daily ongoing cost of accommodation per person[277]



- Programs that support discharge from acute mental healthcare or prisons can prevent people residing inappropriately within institutional care or being discharged into homelessness. For example, an evaluation of the Queensland Government's Transitional Housing Team program found that participants experienced significantly fewer inpatient bed days and improved living conditions[278]. This reduced the average cost of health service use by about $38,600 per participant and offset the program's $31,200 per participant cost. In addition, the program provided an estimated return on investment of about $1.24 per dollar invested.
- Additionally, psychosocial support programs like the *Housing and Support Program* (HASP) decreased the average time spent inpatient care from 227 days to 19 days per year[279]. This program was subsumed into the NDIS as these clients were eligible to receive NDIS. However, this program has not been replaced with an equivalent program for persons ineligible for the NDIS.
- Improving housing stability for people living with significant and persistent mental illness has demonstrated improvements in health, community participation, education and employment outcomes, and reduced interactions with emergency, acute and tertiary services. The success of integrated supports for people with a mental illness that focus on joint solutions across the complexities of their circumstances, including health, employment, social connection and family,

are well recognised. For example, recent research found that job placements increased by 71 per cent with the implementation of psychosocial interventions[280].

- It is well evidenced that tenancy support services can be highly effective at stabilising housing and are cost-effective for governments and the broader community in preventing eviction, homelessness, and deterioration in mental health[281]. For example, Zaretzky and Flatau (2015)[282] estimated that the average cost of providing support to maintain a tenancy was approximately $5400 per presenting unit head (household) compared to $11,000 per eviction event. However, tenancy support services are most commonly associated with the social housing system, with limited support available to people who are in private rental accommodation.
- Furthermore, the Haven Foundation model provides long-term Housing and psychosocial support for people with severe and enduring mental illness. This model seeks to maximise independence, quality of life outcomes and recovery. An evaluation of the Haven South Yarra found the model improved tenancy stability, social connectedness, a sense of belonging and hope for the future and contributed to managing mental health issues[283].
- The Mental Health Demonstration Project was a collaborative approach between Queensland Heath, the (former) Department of Public Works and Housing, and NGO partner Footprints Community. This Project sought to trial an integrated housing, mental health, and welfare initiative to assist social housing tenants to sustain their tenancy. An evaluation[284] of the Project found that almost all tenants had:
    - experienced improved housing situations
    - received fewer complaints, breaches, and warnings (indicators of tenancy problems)
    - improved relationship with their housing office
    - accessed and engaged more with clinical mental health services
    - experienced significant improvements in health and social functioning, and
    - experienced improved mental health and wellbeing.
- Social housing workers and private real estate agents perform an essential role to support people to maintain their tenancies. Moreover, the frontline housing workers are the first to identify tenants who may be experiencing vulnerability and link them with the necessary support. Frontline housing workers must increase their capacity to reduce the risk of people with mental illness experiencing housing issues
- Responding to the needs of Queenslanders is a clear priority for the Queensland Government. The *Queensland Housing and Homelessness Action Plan 2021–2025* (the Action Plan) commits to enhancing the *Coordinated Housing and Homelessness Response* in priority locations across the state to identify people experiencing homelessness and to coordinate services for people with complex housing and support needs.
- The Action Plan commits to a range of actions that contribute to Queenslanders' mental health and wellbeing, including ending homelessness by supporting vulnerable people to stay in their homes. This will be achieved by better coordinating and integrating services across government and the housing sector and developing a new framework to ensure no person exits from another government service to homelessness.
- Queensland's homelessness response[285] recognises that stable, sustainable, affordable, longer-term housing combined with appropriate support is critical to helping people stay in their homes, achieve improved whole-of-life outcomes, and reduce demands on government services. The Plan's actions recognise that responding to housing need and moving towards ending homelessness are objectives and outcomes shared across the community and government at all levels. Key actions driving this direction include:
    - Action 6 — prevent homelessness and support vulnerable people to stay in their homes

- Action 7 — develop a formalised service delivery framework between state government agencies to prevent people exiting government services into homelessness:
  - better use of investment across government to respond to the needs of people experiencing, or at risk of homelessness
  - clear roles and responsibilities
  - improved information sharing and formalised referral pathways between agencies to strengthen responses for people with complex needs
- Action 9 (and sub-actions) — deliver integrated health and housing responses
- Action 11 — assist vulnerable young people to achieve social and economic independence through an integrated housing framework with supports.

- The Queensland Government further recognises the critical importance of social housing supply for Queenslanders. In the 2021-22 Budget, the Queensland Government invested $1.908 billion over four years into social housing and homelessness support, with $314.9 million of this new funding. Additionally, the Queensland Government has also created a $1 billion Housing Investment Fund to supply a pipeline of new social housing.

Recommendation 36: Develop a supported social housing growth plan that identifies a dedicated number of social housing offerings to support people with mental illness and Alcohol and Other Drug problems to secure stable and safe housing.

Recommendation 37: Develop tailored social and private rental tenant support programs that recognise the variable capacity and care needs of people experiencing mental health and alcohol and other drug problems, similar to the Housing and Support Program and Mental Health Housing Demonstration project.

Recommendation 38: Address the shortfall in the number of supported housing places for people with lived experience of mental ill-health, and problematic alcohol and other drugs by providing a range of long-term cluster housing options between ten and sixteen individual units, where the support is provided through NDIS, such as the Mantle, Haven, and so forth.

Recommendation 39: Address the gap in homelessness services for people with mental illness and alcohol and other drug problems, including scaling up longer-term housing options such as Housing First programs, including an additional two to three Common Ground models.

Recommendation 40: Better use the private rental market to provide diverse housing options to suit a range of different needs, including head lease arrangements and lead tenant models.

Income and employment support

- Employment can be crucial to positive mental health and wellbeing. People who are meaningfully engaged in education, training, and employment tend to have better mental health and well-being and are more involved in their community[286].
- Workforce exclusion is a complex and enduring problem in Australia. Some job seekers are more likely to be disadvantaged in the labour market than others, contributing to reduced productivity, lower wages, reduced economic growth, lower taxation-based revenue, and higher welfare.
- People with a lived experience also face additional challenges in obtaining and keeping paid work, particularly employment of their choosing. Job seekers in vulnerable cohorts, including those experiencing mental ill-health, are more likely than others to face stigma and discrimination and be disadvantaged in the labour market[287]In 2018, 25 per cent of working-age Australians with a psychosocial disability, aged 15–64 years were employed, compared to 5 per cent of people

with other disabilities and 80 per cent of the general population. In addition, 85 per cent of people with a psychosocial disability reported employment restrictions because of their disability compared to 60 per cent of those with other disabilities[288].

- This highlights considerable scope to reduce barriers to economic participation and improve mental health outcomes through education, training, and employment.
- Queensland and Australian Government agencies contribute to and make significant investments in services and programs that indirectly prevent and reduce the impact of mental ill-health, problematic alcohol and other drugs use and suicide. Programs including *Job Services Australia* (JSA) and *Disability Employment Services* (DES) seek to support people with mental ill-health or problematic alcohol and other drugs use to enter or re-enter employment.
- *JSA* provides one-on-one individualised assistance and tailored employment services. JSA Providers are organisations contracted by the Australian Government to provide employment services and are available across Australia in more than 2,000 locations. Providers can deliver or connect people to a wide range of government initiatives that offer skills development and training.
- The current employment services delivery model, delivered under JSA, presents barriers for people with moderate to severe mental illness and problematic alcohol and other drugs use.
- Providers often focus on finding employment for easier clients to maximise their placement numbers and milestone payments and protect their labour market resources. This is due to limited entry-level positions in the labour market, and providers are incentivised to get the most suitable clients into placements quickly.
- Building employer partnerships and designing roles to suit individual needs is difficult and demanding. Time and effort are better spent on job-ready candidates in the current employment services model. This leads to providers spending less effort on clients with more significant barriers to job entry (including those with severe mental illness and alcohol and other drugs use) and focusing on job-ready candidates.
- DES assists people with mental illness and problematic alcohol and other drugs use to prepare for, find, and keep a job.
- DES providers are a mix of large, medium, and small for-profit and not-for-profit organisations experienced in supporting people with disability and providing assistance to employers to support employees with disability in the workplace. DES can provide specialist assistance and ongoing support to help participants maintain their mental health and wellbeing and manage their job.
- People with lived experience, supported by DES, who have secured employment in social enterprises did not qualify for ongoing support under the model, despite being paid at the award wage. This highlights a significant challenge for gainfully employed people who may still need ongoing wrap-around support to manage their mental health and well-being and/or alcohol and other drugs use.
- The *Individual Placement and Support* (IPS) model has demonstrated effectiveness and provides the government with a proven intervention with long-term savings implications.
- The IPS program aims to improve the educational and employment outcomes of young people aged up to 25 with mental illness. The IPS program integrates employment and vocational services with clinical mental health and non-vocational support and focuses on the individual needs of people with mental illness seeking to enter, or remain in, education and/or employment.
- Although the roll-out of the IPS model targeted people with serious mental illness, there are still a significant amount of people with mental illness continue accessing mainstream services. In late 2021 around 13 per cent of jobactive caseloads and 40 per cent of DES caseloads were people with lived experience (around 185,000 people). However, mainstream services providers often lack the capacity and capability to meet needs of people with mental illness.

- Participants can access a variety of supports, including job coaching, assistance navigating community support services and Centrelink systems, targeted education and/or employment opportunities, and on-the-job support for as long as needed.
- A review of the IPS trial in Australia conducted by the Productivity Commission found that the program successfully supported people with mental illness to enter and remain in education and employment.
- The review found that IPS programs achieved more successful job placements for participants when they included workplace skills and interpersonal skills training, as participants may have limited work experience. The evidence showed significant positive effects for young people experiencing homelessness, in particular.
- The *New Employment Services Model* will replace the jobactive program from 2022. This new model aims to provide intensive case management to job seekers who need extra support through an employment services provider to prepare and support them into work.
- The model claims that enhanced employment services will provide high quality individualised service and a focus on early intervention and safeguards. Additional supports, wage subsidies and an Employment Fund will also be available for the most disadvantaged.
- Although employment services are predominantly the responsibility of the Commonwealth Government, Queensland Government programs such as *Back to Work* (BTW) and *Skilling Queenslanders for Work* (SQW) have a vital role in improving employment outcomes for Queenslanders.
- These programs focus on employment readiness and skills development and have been relatively successful in helping people in vulnerable cohorts to prepare for entering or re-entering work[289].
- Despite this, more targeted approaches are needed to support at-risk cohorts and people with mental ill-health and problematic alcohol and other drugs use to find and benefit from employment.
- However, more is needed that is specifically targeted at people with mental ill-health and problematic alcohol and other drugs use. Both the Commonwealth and State governments have funded the development of various social enterprises focusing on vulnerable Queenslanders, including people living with mental ill-health and problematic alcohol and other drugs use.
- Social enterprises seek to address social concerns, improve communities, or provide access to employment and training. Their income is sourced from trading, with most profits reinvested to support their overarching goal[290].
- Increased investment and resources are required to support the establishment of medium-to-large social enterprises. The social enterprise model of employment for people with mental illness provides an opportunity to create supportive environments for workers that are likely to have the strongest positive impact, help break down stigma and discrimination, and ensure a greater likelihood that workers will remain employed long-term[291].
- Studies in Scotland[292] and Australia[293] have shown that social-purpose companies benefitted employees with a mental illness by providing social and vocational skills and a sense of inclusion and distraction from psychological symptoms and worry. Other studies have shown that a pleasurable and supportive environment with positive physical and mental stimuli, combined with strong relationships, are critical to overcoming problematic alcohol and other drugs use[294].

Recommendations 41: The Queensland Government establish an interagency working group across the health, schooling, tertiary and vocational education sectors to work on improving participation and completion of education and training targeting all marginalised and/or disengaged individuals, including those with mental health and drug and alcohol problems.

Recommendation 42: The Commonwealth and State Governments investigate further incentives and supports for employers to take on disadvantaged workers such as tax incentives and through the PAYG system. As demonstrated through the highly effective Back to Work (BTW) program in Queensland, employer incentives have been successfully used to support people from disadvantaged cohorts to gain and sustain employment.

Recommendation 43: The Queensland Government should continue to strengthen successful and emerging social business models that leverage public and/or private sector resources and build on existing Government initiatives, such as Skilling Queenslanders for Work, that provide pathways into work for highly disadvantaged and at-risk cohorts in Queensland, including those with mental illness and problematic alcohol and other drugs use.

Recommendation 44: The Commonwealth and State Governments should continue to support the establishment of medium and large jobs focused social enterprises through establishment funding, access to government capital assets and through procurement of a percentage of government business to social enterprises.

Recommendation 45: The Commonwealth Government should expedite broader implementation of the Individual and Placement Support (IPS) model of employment support beyond its current application and expand it to include people of all ages through a staged rollout across metropolitan and rural and remote Queensland. This will require collaborative work with the Queensland Government to integrate the IPS with State Government employment readiness programs such as Skilling Queensland and the Back to Work programs.

3.8 Support people who are in significant distress or crisis

- Suicide is a significant public health policy issue with wide-reaching impacts. Suicidal distress, suicide attempts and suicide will affect most Queenslanders at some point in their lives, often with long lasting and far-reaching impacts.
- Queensland consistently records suicide rates above the national average and in 2020 had the second highest number of suicides (759) behind New South Wales (876), and the third-highest age standardised rate of suicide among all states and territories (14.7), behind the Northern Territory (20.4) and Tasmania (15.9).[295]
- Suicide is the leading cause of death for young people aged between 15–24 years[296]. Suicidal ideation is more common among young women, and young men are more than twice as likely to die by suicide. This is broadly reflected in the population more generally, as men are more likely to choose more lethal means to suicide. However, it is noted that recent information from the Queensland Suicide Register suggests that this gender difference in lethality of means is changing, with females increasingly choosing more lethal means.
- The age distribution of suicide rates for Aboriginal and Torres Strait Islander people are different from the general population. For Aboriginal and Torres Strait Islander people, the median age at death by suicide is 29.5 years, compared with 45.4 years for non-Indigenous Australians[297].Suicide rates for Aboriginal and Torres Strait Islander people are highest during early to mid-life, and then fall among the older age groups. Suicide is the leading cause of death

for Aboriginal and Torres Strait Islander people aged between 15–34 years, representing more than two-thirds of deaths by suicide by Aboriginal and Torres Strait Islander people.

- In addition to the social and emotional cost on those who are left behind, the economic cost of diminished health and reduced life expectancy for those with mental ill-health, self-inflicted injury and suicide total approximately $151 billion. About 80 per cent is attributable to mental illnesses ($122 billion) and the remainder attributable to death by suicide ($29 billion).[298]

Psychological distress

- Psychological distress is a state of emotional suffering and anguish that presents with similar symptoms to depression and anxiety. Psychological distress is influenced by situational circumstances in a person's environment or social relationships and is exacerbated by social inequality[299].
- Social factors such as unemployment, homelessness, financial stress, and interpersonal conflict are linked to increased psychological distress and are also known to be connected to increased risk of suicide.[300] Psychological distress can have adverse effects on a person's emotional wellbeing, their relationships with the people around them, their quality of life, and may also serve as a warning sign for suicidality.
- Experiences of psychological distress are common in Queensland, with 14 per cent of persons aged over 18 years who report having high or very high psychological distress in the most recently available data[301]. This is higher than all other states and territories and the national average of 13 per cent of the population.
- Psychological distress does not affect all Queenslanders equally with around 3 in 10 Indigenous Queenslanders reporting high to very high levels of psychological distress (31 per cent, age-standardised)—a proportion that has not changed significantly since 2008—compared with 13 per cent of non-Indigenous Australians.
- However, with the correct support, psychological distress, is a recoverable disruption to a person's social, psychological, spiritual or health needs.
- To appropriately respond to psychological distress, appropriate responses must be available early, be easily accessible, and meet the underlying support needs of people in crisis. They should aim to, where appropriate, enhance a person's social connectedness to family, schools, workplaces, friends, and communities.
- Currently, responses to people in psychological distress include a focus on deescalating and assessing a person's risk of harm to themselves or others. However, for responses to be effective, they cannot focus solely on assessing risk, and instead need to focus on identifying and responding to the underlying environmental and social factors that contribute to a person's distress.
- As psychological distress is heavily influenced by these environmental and social factors, responses to psychological distress should not necessarily be medical.[302] Responding to the social and situational contributors of psychological distress is an opportunity for the system to intervene early and prevent a person's escalation to the point of crisis.
- Some people who are seriously distressed may reach a crisis point and require more intensive and immediate support, including from services led by caring, competent and skilled support workers, including clinical and non-clinical workers from a range of disciplines include health, peer support and cultural support.
- However, currently an overreliance occurs whereby the default model to respond to those who experience psychological distress are emergency responses through police, ambulance, and ultimately emergency departments. These are not best placed to respond to those who are distressed and in crisis for a variety of reasons, including relevancy of training to deliver an appropriate response.

- People in distress may not have prior contact with services or may not have information about where to go for the most appropriate support. However, most people do have contact with a range of generalist services and the majority of these are outside of the health system. When these generalist services have contact with people who are in distress, they need to be equipped to appropriately identify, support, and respond. This means that appropriate knowledge and skills need to be developed across all touchpoints of the service system so that services are equipped to respond and refer people to appropriate pathways.
- To achieve this, models outside of the health portfolio are required so that the default responses for people who are at a lower level of acuity are not via the emergency departments or accessed through police or ambulance. There are promising models that have been developed in other jurisdictions that could be adapted or trialled to the specific geographic and demographics of Queensland – however, these models need to be developed and delivered and supported by workforce training.
- Queensland continues to explore options similar to the Distress Brief Intervention (DBI) model that originated in Scotland during the development of their suicide prevention plan. The DBI model was developed in recognition that a large proportion of people who take their lives do not necessarily have an underlying mental health issue but who have otherwise experienced distress as a consequence of situational factors in their lives. Accordingly, the DBI model aims to improve responses to all people who present to frontline services in distress or in crisis, regardless of the cause or the agency they present to.
- This includes an emphasis at two levels – frontline workers across government have basic mental health first aid training (de-escalation and compassion focus) who are able to identify people who are distressed and refer them to a specialist non-government organisation (with the person's consent) to work intensively with the person to resolve their problems or stressors. The initial findings of the Scottish DBI model are positive but require consideration and adaptation to the unique Queensland context.
- Aside from the specific model or approach, several important elements are required to deliver an effective, compassionate, and appropriate response to those in distress:
    - Training and support of community and service touchpoints in understanding and responding to distress. This includes equipping frontline workforces in Queensland with a level of awareness and understanding of distress to identify early, provide compassionate support as appropriate, and awareness of how best to support or refer the distressed person.
    - Establish clear and easily understandable pathways for a stepped response to appropriately support people who are in distress, including in identifying when additional specialist knowledge and skills are required. Currently, this is a service gap that requires further consideration of optimal design to deliver an effective response.
    - Strengthening community infrastructure such as neighbourhood centres and community services to be equipped and resourced to provide early support and response to the underlying contributing factors and amplifiers of situational distress and crises. Consideration of this element should be aligned with Queensland Government intention to develop a social isolation and loneliness strategy.

Recommendation 46: Work with state and national stakeholders to develop and implement a model to respond early to all members of the public who present to frontline services in distress or in crisis, regardless of the cause or the agency they present to. This should include consideration of a stepped response for frontline services to appropriately identify people who are in distress, offer compassionate support and referral to services with appropriate knowledge and skills as required.

This should draw on known models such as Distress Brief Intervention and adapt to the specific service mix and spread in the Queensland context and, where needed, develop the capacity for tailored and intensive psychosocial support. Implementation should include identification of the cross-agency investment model, outcomes, and governance required.

Crisis response

- According to data provided by Queensland Health, 25 per cent of people who died by suspected suicide in Queensland had received care from a Queensland Health service within one month prior to their death. There is also evidence to suggest that a significant proportion of people who die by suicide in Queensland have had contact with a primary healthcare provider prior to their death.
- A significant program of work has been undertaken to develop and deliver service enhancements to improve responses to people in crisis. In the 2019-20 Queensland Budget, several initiatives were funded in Queensland to better respond to those in crisis:
    - $10.8m over four years to establish eight Crisis Support Spaces near hospital emergency departments for adults experiencing mental distress or suicidality to deliver support from peer workers or clinicians with a view to divert avoidable hospital presentations.
    - $11.3m over three years to establish and operate a Crisis Stabilisation Facility at the Robina Hospital to serve as an alternative to the emergency department for adults experiencing mental distress and/or suicidality of a higher level of acuity.
    - $7.5 million to expand the number of sites hosting a Way Back Support Service to support people after they have attempted suicide.
- In addition, Queensland Health is supporting enhanced aftercare service responses for people who present to a hospital following a suicide attempt of suicidal crisis a period of significantly increased risk of re-attempts or death. The Way Back service models are being trailed in 10 locations and provide one on one non-clinical aftercare support for up to three months. Based on the experience of the Queensland trials and in other states investment in after care support should be prioritised.
- The evaluation of the Way Back Support Service is due in December 2022, but preliminary results are promising in reducing psychological distress and suicidal ideation. Based on the experience of the Queensland trials and the investment of other states and territories in aftercare support, this type of support should be prioritised for expansion.
- When people are in crisis, they overwhelmingly access supports through hospital emergency departments, police, and ambulance. Patients with mental health needs are 16 times more likely than people with other conditions to arrive via police, and nearly twice as likely to arrive via ambulance or helicopter rescue.[303] In recognition of this, the Queensland Government has committed to the delivery of a Mental Health Co-Responder Model[304], a collaborative model between Queensland Ambulance Services, Queensland Police Services and Acute Care Team clinicians to jointly respond to people who are in mental health crisis after emergency calls are received.
- Data collected from the trial indicates that the model is proving to be effective, and the model has now been extended to the include an addition site at the Princess Alexandra Hospital. While the Queensland Government has supported this model and it is showing promising results, it is important to acknowledge that this response may not be culturally appropriate for all people, and this may limit its effectiveness.
- For example, there is evidence to suggest that interactions with police, particularly for First Nations people, may increase distress and may escalate the situation. This issue was recently highlighted by the Queensland State Coroner, Mr Terry Ryan, in his January 2022 findings at inquest in the death of Noombah, a 39-year-old First Nations man from Townsville.[305] Noombah died while detained by police under an Emergency Examination Authority (EEA) and transportation to hospital by ambulance after his partner contacted authorities concerned for Noombah's welfare after he had consumed inhalants.

- In his findings the State Coroner noted that the only option considered by police was detaining Noombah and transporting him to hospital and highlighted this contrasted with Queensland research[306] that identifies there is limited evidence that transportation to hospital is an optimal response for a person who is in crisis.
- The State Coroner recommended that the Queensland Government work with First Nations peoples in Townsville, the Northern Queensland Primary Health Network an organisation such as Thirrili to develop culturally appropriate referral pathways for First Nations people in mental health crisis as an alternative to assessment in hospital emergency departments. The Queensland Government is considering its response to this recommendation.
- However, when people arrive at emergency departments in mental health crisis, via first responders or alternative means, they routinely experience unreasonably long wait times in environments that are inappropriate or distressing for them. According to the Australasian College for Emergency Medicine, people with mental health needs presenting to an emergency department, wait longer than other patients with physical illness of similar severity, experience a longer treatment period, and are more likely than other patients to leave the emergency department against medical advice and prior to their treatment being completed[307].
- People with lived experience have reported that emergency departments can increase distress and impact upon their recovery and have identified the clear need for services that are respectful, culturally appropriate, and compassionate to respond to people who are in mental health crisis. This perspective is mirrored in the submission to this inquiry provided by Queensland Health, and the Commission supports the department's call for a shift away from siloed approaches to mental health crisis reform and a shift to a focus on the whole crisis system of care.308
- Queensland Health's implementation of the Zero Suicide in Healthcare approach is an example of a systems response to suicide prevention. Most people who die by suicide do not have a mental illness and may not have been identified as high risk in prior contacts with health services.
- The Zero Suicide approach recognises this and is designed to enhance the capacity of the health system to identify, assess, treat, and provide follow-up care for people who present to health services in a suicidal crisis.
- The focus is on driving cultural and clinical change across the 12 participating HHS and shifting away from attempting to predict who may go on to die by suicide, and instead focus on prevention responses to those who present in suicidal crisis regardless of the person's mental illness or identified risk level. This could include safety planning, restricting access to lethal means, and offering follow up support services in the community.
- Queensland Health has reported that implementation of this approach, while resource intensive, has shown a meaningful reduction in people re-presenting to health services with a suicide attempt after they have been supported through the Zero Suicide approach. An adaptation of the Suicide Prevention in Healthcare initiative has also occurred through the Generation Zero Suicide (GenZs) initiative in Children's Health Queensland, and there is consideration of an adaptation for older persons.
- Currently there is a small amount of funding provided by government to support this work and additional funding would support expansion of this model across Queensland and consolidate and embed system improvements through this approach.
- Queensland Health is driving a systemic continuum of care approach to mental health crises and has demonstrated a commitment to improving the outcomes for people in crisis in a tailored and targeted way. The systemic approach adopted by Queensland Health reflects the dynamic nature of crisis and the need to ensure that these responses are supported by enhanced organisational readiness and capacity, alongside the implementation of additional programs.

- This includes workforce capability, enhanced data and information systems and cross sector service planning and pathway development, to ensure that improvements are sustained and embedded.
- There are international examples that Queensland can build on to deliver meaningfully and holistic reform to the crisis system in Queensland and shift beyond a piecemeal approach. In the United Kingdom, the government has published a joint statement that describes what people experiencing a mental health crisis should be able to expect of the services that are there to help them and articulates how different government and non-government organisations should work together to support those who are in crisis.[309] This includes key principles that could be built on to inform Queensland's crisis reform approach, including:
    - Early intervention and access to support before reaching crisis point
    - Urgent and emergency access to crisis care
    - Quality treatment and care when in crisis
    - Prevention of future crises and support to stay well
- The Productivity Commission (2020) [310] also considered what a model of improved crisis care would look like in its inquiry into mental health and tangible options to improve systems for consumers, including:
    - offering improved alternatives to emergency departments, including after-hours alternatives and community-based crisis services.
    - improving the experiences of people who attend emergency departments in mental health crisis, through dedicated spaces within the emergency department for people experiencing mental illness or altering the physical environment of the emergency department to suit the needs of people with mental illness.
    - increasing the availability of mental health beds and particularly for vulnerable groups such as children and young people.
- There is a clear need in Queensland to better connect the pockets of good practice to deliver an improved crisis response model, and to scale up existing programs and initiatives to ensure there is equity in accessibility and availability of alternatives to emergency departments and diversionary services. This should include strengthened relationships and alignment with the Commonwealth Government to most efficiently leverage state and commonwealth funding to deliver tailored responses to the population or region and continually evolve in response to the emerging evidence base.

Recommendation 47: Aligned with the planned approach by Queensland Health to establish a continuum of crisis response prioritise the scaling up of existing and new mental health crisis programs and initiatives that demonstrate clinical and cost effectiveness to ensure equity of access to these services across Queensland.

Recommendation 48: Support and resource Queensland Health's development and regional implementation of a comprehensive strategy for mental health crisis reform to ensure all regions have access to appropriate crisis support.

Evidence-based prevention

- Data and surveillance form the foundation of the public health model of suicide prevention. Monitoring of suicide, suicide attempts and crises is critical for providing an understanding of the nature of suicide in Queensland and assist the early identification of trends and factors to inform effective prevention and response measures. Collection and reporting of this data can inform and improve responses across the continuum of prevention and at the individual, interpersonal, community and societal levels.

- In order for suicide prevention initiatives to be most effective, accurate and timely data and information is required by stakeholders at various levels of intervention across the continuum of prevention, including policy, community, academic, and non-government stakeholders. This data and information need to be collected, translated, and disseminated in a way that is aligned to the purpose and context of end users to be used most effectively.
- Queensland was the first Australian jurisdiction to develop a register for suicide deaths in the late 1980s and early 1990s, through the Queensland Suicide Register (QSR). The QSR is a surveillance system that records all suspected suicides by Queensland residents from 1990 where the coronial investigation is finalised.
- The QSR provides information on suicide rates over time, demographics, and case characteristics. Improvements have been made over time to provide timelier preliminary reporting, through the establishment of the Interim QSR (IQSR) in 2011. Data from the QSR remains limited to quantitative data and the QSR is not designed to provide deeper qualitative analysis of cases or clusters of cases to explore prior service system contact and inform understanding of systemic opportunities for death prevention.
- Data is not as consistently available and accessible for suicide attempts and crises in Queensland. Agency level data is available in relation to suicide attempts across primary responding agencies such as Queensland Health and Queensland Police. However, this is not consistently available or reported in Queensland for all relevant agencies and systems are not established for this purpose.
- In Queensland, there is growing recognition of the importance of rich and more accessible data for providing greater insight into systemic opportunities for prevention. Notable examples exist in other areas of death prevention in the form of specialised mortality datasets for domestic and family violence suicides (through the Queensland Domestic and Family Violence Suicide Dataset at the Coroners Court of Queensland) and child deaths including child suicides (through the Child Death Register at the Queensland Family and Child Commission). These approaches are either embedded within, or have strong links to, systemic death review processes and are informed from a wider variety of data sources and are able to provide richer quality information in addition to quantitative data.
- In recent years significant enhancements have occurred in suicide surveillance across Australia. These include the establishment of suicide registers in other states and territories and more recently the National Suicide and Self-harm Monitoring System.
- While data systems now exist that provide an understanding of suicide at a state and national level over time, this is an incomplete picture, with information being limited to suicide rates, characteristics, and basic demographic information. This means that there is an incomplete understanding of any potential points of intervention prior to a death, such as information in relation to when, where and how people present to services prior to a death that could lead to improvements in system responses.
- To address this, the Queensland Mental Health Commission is undertaking a pilot systemic review of male suicides project in partnership with the Coroners Court of Queensland (CCQ). The systemic review is an innovative project that aims to extend our knowledge of why men are over-represented in suicide deaths in Queensland at 3.6 times higher rate and what more can be done at a systems level to reduce or prevent these deaths. This resource will be used to inform the development of a men's suicide prevention strategy and coronial investigation guidelines for suicides.
- An external expert, Dr Samara McPhedran, has been engaged to review a cluster of male deaths by suicide and has been granted access to coronial investigation documents to inform this review. While these findings are preliminary only, there are already tangible themes emerging for the Commission to prioritise in working with other government and non-government stakeholders, including:

  - 40.6 per cent of cases had contact with health services in the six months before the death, including through their GP or public mental health services.
  - 44.5 per cent of men had a known criminal history – substantially higher than for the general population

- There were also issues identified in community-based service provision, relating to a lack of understanding by GPs about psychosocial support services, suicidality more generally, and a 'medicalisation' of psychosocial problems.
- There were also issues identified in the 'inclusion/exclusion' criteria applied by services, resulting in some people (particularly those experiencing alcohol or other drug use) being turned away from services for not meeting the eligibility criteria.

Governance, oversight, and coordination

- Queensland has a longstanding whole-of-government approach to suicide prevention which recognises that suicide is preventable and the vital importance of working across government, non-government, and cross-sectoral stakeholders to reduce suicide. Queensland's current whole-of-government suicide prevention approach is outlined in *Every life*.
- *Every life* provides Queensland's renewed approach for suicide prevention and emphasises the vital importance of working together and incorporating the voices of people with lived experience of suicide as crucial to effective efforts to reduce suicide.
- Implementation of *Every life* was designed to occur across three phases, and to be reviewed at each stage and the review outcomes used to inform the development of the subsequent stage. The first phase recently concluded with substantial contributions of 13 Queensland government agencies working together to deliver a range of commitments across the four focus areas. This includes significant innovation and response expansion in important areas including, but not restricted:
  - Queensland Health's implementation of the Zero Suicide in Healthcare framework to that is designed to enhance the capacity of services to identify, assess, treat, and provide follow-up care for people who present to health services in a suicidal crisis. This builds on service enhancement over years including the work of the Queensland Taskforce for Suicide in Health Services.
  - The work of the Office of Industrial Relations to support mentally health workplaces, and the support for people who have experienced a psychological injury at work through delivery of the Workers Psychological Support Service and improving claims experience for first responders diagnosed with posttraumatic stress disorder.
  - The work of the Department of Education to improve systemic access to mental health and wellbeing supports for students, through the permanent appointment of specialist mental health roles, responsible for embedding the department's Student Learning and Wellbeing Framework, integrating social and emotional wellbeing across the curriculum and support students with complex mental health needs to provide them with long-term support.
- A process to formally review the first phase of *Every life* is underway and will be completed during the first half of 2022. This will explore the implementation and impact of Every life phase one and will inform the priorities of the next phase.
- Since the release of *Every life,* the Australian Government has renewed a national focus on suicide prevention including the delivery of the National Suicide Prevention Adviser's Final Advice to the Prime Minister. This sets forth eight priority areas to enhance suicide prevention responses:
  - whole-of-government and cross-government approach to suicide prevention
  - lived experience and leadership in all elements of policy and program planning and delivery

  - ensure a strong evidence-based foundation to suicide prevention policy and initiatives
  - enhance workforce and community capability in suicide prevention
  - respond earlier to distress
  - connecting people and compassionate services and supports
  - target groups disproportionately impacted by suicides, and
  - policy responses to improve security and safety.

- Queensland is well-positioned to capitalise on the revised national approach to suicide prevention as these priority areas are well aligned with those outlined in Every life. This highlights Queensland's long-standing adoption of a whole-of-government and cross-sectoral suicide prevention approach as an exemplar of effective strategic approach.
- Oversight and monitoring for Queensland's suicide prevention plan is through the Shifting minds Strategic Leadership Group with alignment and support facilitated and enabled through connections across a range of other cross sectoral mechanisms.
- A Queensland Suicide Prevention Network is being established to provide a forum for joint planning and coordination of state, national and regional suicide prevention initiatives, and to strengthen cross sectoral engagement and integration. An interim Network is supporting the development of the longer-term Network.
- However, there are opportunities for Queensland to further strengthen suicide prevention responses and governance beyond the health portfolio and to leverage the developments at the national level to deliver a more integrated response across levels of government.
- In contrast, although lived experience innovation and leadership has catalysed and expanded nationally and internationally including through Mates in Construction and Roses in the Ocean, and to a positive extent within the health portfolio, Queensland's whole-of-government engagement of lived experience leadership through all stages of policy planning and implementation requires further maturity.
- Consistent with *Every life*, and consistent with the findings of the National Suicide Prevention Advisor's Final Advice, Queensland's immediate priorities for cross-sectoral planning and implementation are on strengthening governance and planning mechanisms, with a focus on:
- State, regional, and national suicide prevention integration
  - To achieve effective and comprehensive suicide prevention it is necessary to jointly establish agreed roles and responsibilities between commonwealth, state, and regional levels.
  - Over time lack of clarity, as well as disagreement about respective responsibilities between levels of government has contributed to duplication, gaps, and inefficiencies.
  - The establishment of the National Suicide Prevention Office as a clear point of national responsibility and planning is welcome and will have a critical role in supporting cross government integration, as well as greater alignment across relevant commonwealth portfolios.
  - It is important that cross government engagement and coordination occurs at the planning stage and not left to the point of implementation.
  - Robust and integrated cross agency and sector governance at the state level is required to engage effectively with the national mechanism, while driving and embedding a cross sector approach.
- Lived experience leadership
  - Significant Queensland lived experience of suicide leadership has resulted in innovative and ground-breaking programs, service models, and advocacy.
  - The impact is demonstrable at state, national and international levels. Roses in the Ocean and Mates in Construction are each recognised for their pioneering leadership and expertise, and stem from a lived experience foundation.

    - Lived-experience led suicide prevention initiatives have been developed and implemented across Queensland, for example – Living Edge Program, PAUSE Program, Brisbane North Safe Space Network, and the Brisbane North Suicide Prevention Network.

- Despite the significant advocacy and practice leadership, formal embedding and integration of lived experience representation and leadership at all levels requires further development.
- Renewed model for suicide surveillance
    - Data and surveillance are critical to the public health model of suicide prevention.
        - Queensland's suicide surveillance system is currently in the Queensland Suicide Register that has been in operation since the 1990s and has not been subject to comprehensive review in that time.
        - Since then, numerous other datasets at the state and national level have developed and a review of this surveillance model will assist in development of an enhanced model that can deliver information about prevalence as well as broader case characteristics, known risk factors and emerging trends.
- In addition, clear priorities in the short-term include developing an integrated child and youth suicide prevention plan, targeted approach to responding to suicide in First Nations communities and building capacity within the Queensland Government to equip all frontline services with the capacity to respond to distress.
- The Commission will work with all partners to take into account outcomes of the review of Every life, national momentum, and the outcomes of this inquiry to continue to develop and drive comprehensive and cross sectoral suicide prevention.

3.9 A renewed approach to alcohol and other drugs in Queensland

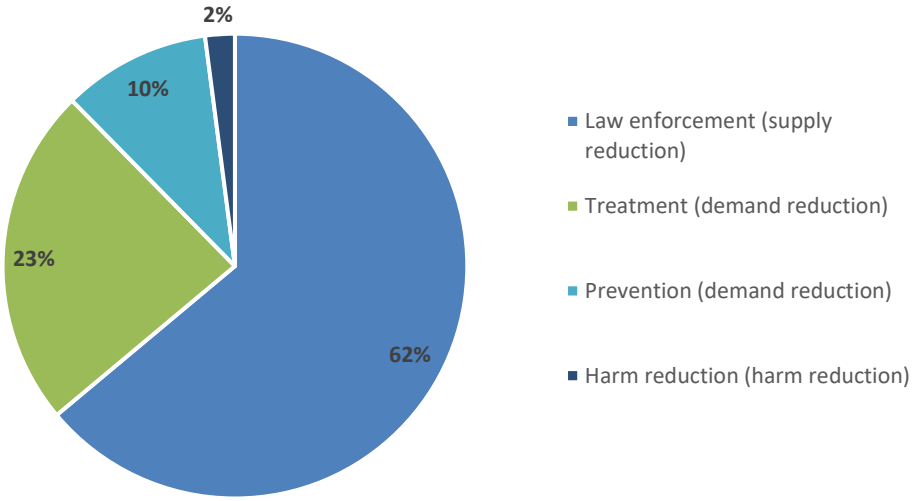
- As part of the Commission's function, the Commission led the development of a whole-of-government, cross-sectoral, renewed alcohol and other drugs plans for Queensland, informed by extensive consultation across Queensland, including government, non-government and community sectors, and people with a lived experience with alcohol and other drugs.
- With strong agreement across stakeholders a proposed whole-of-government plan has been developed to provide the renewed strategic direction for alcohol and other drugs in Queensland and is pending Government consideration.
- It is proposed that the recommended renewed direction will also provide the governance mechanism for coordination across the non-government and government sectors, which is currently lacking in Queensland.
- Central to the renewed direction is a more coordinated system to create the balance across the pillars essential to minimising harm: harm reduction, demand reduction and supply reduction.
- Implementation promises also to alleviate downstream pressures on emergency departments and hospital beds and the criminal and youth justice, child safety, and domestic and family violence sectors.
- The strategic intent and implementation will support and integrate the plans and directions being progressed through Queensland Health, Queensland Police Service, Queensland Corrective Services, Department of Justice and Attorney-General, and the Department of Communities, Housing and Digital Economy and others. It will also have relevance for the priority reforms under the National Agreement to Close the Gap in creating genuine partnerships with government organisations and shared access to data and coordination at a regional level.

- A renewed approach for alcohol and other drugs in Queensland will provide endorsed strategic direction and provide a framework to guide new investment and repurposing across the sector.
- Queensland alcohol and other drug services provide quality services across client groups, treatment types and geographic locations, which are well-utilised by Queenslanders; however, there is greater demand for services than the current supply of services.

Recommendation 49: Endorse and implement Queensland's renewed whole-of-government approach to alcohol and other drugs.

- Queensland alcohol and other drug services provide quality services across client groups, treatment types and geographic locations, which are well-utilised by Queenslanders; however, there is greater demand for services than the current supply of services.
- Despite significant investment, the alcohol and other system are currently only meeting an estimated 26 to 48 per cent of service demand[311].
- Investment to date has focused on areas of high demand and system pressure, but gaps remain, particularly in prevention and harm reduction (**Figure 15**).

Figure 15: Area of allocation by harm minimisation pillars[312]



- Harm reduction services such as needle and syringe programs, community access to take-home naloxone, drug checking (also known as pill testing) and medically supervised safe injection centres consistently demonstrate outcomes such as reduction in transmission of blood-borne viruses and reduced drug-related deaths[313].
- Importantly research has shown that drug use does not increase with harm reduction services314.
- Naloxone is a pharmaceutical product that can reverse an opioid overdose. It is easy to administer, similar to an epi-pen used for allergic reactions. Increasing access to take-home Naloxone by distributing Naloxone through peers, upon release from prison, distributed by paramedics, and Naloxone carried by police are opportunities that are not currently available in Queensland. Increasing the availability of take-home naloxone is a highly cost-effective measure to reduce drug-related overdose deaths and reduce demand for emergency services and

hospitals. Every $32.50 spent on one dose of Naloxone saves high costs in hospital admissions and the potential ripple effect in the community from an opioid overdose.

- Opioid use is a significant driver of drug-related mortality and morbidity; compared to the general population, people who use opioids have a 15-fold increased risk of death. Those who inject opioids have a greater risk of overdose than people who use drugs by other routes of administration[315].
- Queensland has needle and syringe programs (NSPs) in locations across the state, a vital harm reduction measure that has been in place for 20 years; there are over 150 public NSPs in Queensland.
- NPSs are service locations already accessed by the injecting drug user population and are the ideal location and service type for increasing access to take-home naloxone and implement peer training programs on the administration of Naloxone.
- QuIHN, a Queensland-based alcohol and other drugs treatment service, provides Naloxone to their clients in Brisbane, Sunshine Coast, Townsville, and Gold Coast but does not have adequate funding for this program. The Commonwealth Department of Health is currently running a 'take-home naloxone pilot' with an investment of $3.9 million in 2021-22; however, Queensland is not part of this pilot program.

Recommendation 50: Enhance the overall funding allocation for alcohol and other drugs urgently increase resourcing across all areas, including harm reduction services.

- Currently, the primary approach to minimising harm from illicit drugs is through a policy of criminalisation.
- The criminalisation of drug use has resulted in unintentional harm. These harms arise because
    - criminalisation incentivises the creation of more harmful and dangerous drugs, and
    - harms arise because the profitability of illicit drugs creates incentives for organised crime to enter into illegal drug markets[316].
- Expanding the diversionary options within the current police drug diversion program to include all illicit substances will assist in reducing the stigmatisation of people with a lived experience and their families, as the criminalisation of illicit drugs is a critical driver in stigmatisation and discrimination.
- The notion that alternatives to law enforcement response to the use and possession of illicit drugs are 'soft' on crime is simplistic and is not supported by the evidence.
- Diversion has the dual capacity to maintain community safety and divert people from a criminal trajectory to a health response while better addressing the underlying issues contributing to substance misuse, such as untreated mental health conditions, history of trauma, and domestic and family violence.
- A criminal justice system response to alcohol and other drugs, in isolation, does not effectively address the underlying issues that are often associated with problematic alcohol and other drugs use, including a history of trauma, co-occurring mental health conditions and disadvantage.
- Vulnerable people can be diverted to health responses such as alcohol and other drug treatment, and those who are occasional substance users can be diverted to credible education and information on illicit substance use as an early intervention measure.
- The criminal justice system faces challenges due to the rate of imprisonment and the cost of incarceration.
- The rate of imprisonment is increasing (the number of prisoners per head of population has increased by more than 160 per cent since 1992), yet crime rates are decreasing[317].

- The current illicit drugs policy has failed to curb supply or use; the policy costs approximately $500 million to administer. According to the Productivity Commission final report – the illicit drugs policy is a crucial contributor to rising imprisonment rates (32 per cent since 2012).
- Survey findings of the Illicit Drug Reporting System – Queensland Drug Trends (2021) found that although the price of crystal methamphetamine increased significantly, from $50 per point in 2019 to $75 per point in 2020, and availability decreased in 2020 compared to 2019 during the COVID-19 pandemic, the availability remained high with 41 per cent of respondents reporting that crystal methamphetamine was “easy” or “very easy” to obtain in 2020[318].
- To enhance current efforts, the Queensland Government is in the process of renewing its policy approaches to alcohol and other drugs to increase the focus on prevention, enhancing treatment services and drug law reform options.
- Drug policy reform in other jurisdictions has demonstrated that benefits can occur when a strong health response supports alcohol and other drugs issues.
- The Queensland Government is committed to supporting law enforcement by developing health-based approaches to illicit drug use.
- This includes a greater focus on harm minimisation for minor illicit drug offences through increased options for police-led drug diversion to early intervention and health response.
- Providing targeted support for people experiencing problems with alcohol and other drugs also increases the safety of the broader community.
- High rates of First Nations imprisonment are undermining efforts to address disadvantages. Currently, a First Nations male has an almost 30 per cent chance of being imprisoned by the age of 25[319].

Recommendation 51: Take forward the implementation of the Queensland Government response to the Queensland Productivity Commission inquiry into imprisonment and recidivism, particularly the recommendations that enhance systems to expand diversionary options to health and community-based responses.

Section 4: enhancing our practices

4.1 Attract, retain, and support the workforce

- The delivery of quality mental health care and support is supported on the knowledge, skills, and expertise of professions to deliver those services. The mental health workforce consists of a diverse range of professions including clinical and non-clinical roles, working across different models of care, across a range of public, primary, private, and non-government healthcare settings.
- To enable workforce recruitment and retention several objectives underpin the appropriate structuring of the workforce. The *Draft National Mental Health Workforce Strategy* identifies key objectives of ensuring that careers in mental health are seen as attractive, that data drives workforce planning, the entire mental health workforce is utilised, the mental health workforce is appropriately skilled, retained and distributed to address population health needs.
- To address the shortages of mental health workers across most occupations and sectors a multi-level approach that confronts the structural (e.g., funding cycles, renumeration), personal (e.g., housing, schooling, lifestyle factors), and professional (e.g., supervision and support, professional networks, education, and training opportunities) factors that are involved in attracting and keeping staff must be taken.
- Workforce models must ensure the appropriate skills (as well as skill mix) are available in regional and rural locations throughout Queensland. Access to mental health professionals, particularly GPs and psychiatrists is much lower in regional and rural locations. According to national figures there are only 6 FTE psychiatrists directly providing services to very remote Australians compared with 2761 FTE in major cities[320].
- Certainly, access to MBS rebated mental health services falls considerably for people in regional and rural areas. $1.05 billion was spent on mental health services which were rebated through MBS in major cities in 2019-20 compared with only $220 million in inner regional areas, $68 million in outer regional area, and $8 million in remote and very remote locations.
- Consideration of the supports required by clinicians to address the unique social, economic, and cultural barriers faced by consumers living in locations outside of metropolitan areas should drive the development of workforce design in addition to addressing the multiple factors that make it less likely for health professionals to work in remote areas (such as professional loneliness, personal costs, heavy workloads).
- Furthermore, the creation of incentivised pathways into perinatal and infant mental health practice for First Nations staff across Queensland. The positions would offer place-based health education to employment programs to increase participation in the workforce via real job outcomes.
- The benefits of these identified positions are two-fold, they will support the provision of culturally safe and inclusive perinatal and infant mental health care and work to improve Aboriginal and Torres Strait Islander peoples' participation in health system workforces.
- Serious commitment to addressing workforce wellbeing by tackling the known predictive and preventative factors of vicarious trauma need to be garnered. Evidence pertaining to the impacts and mediators of compassion fatigue and cumulative stress on staff working in different mental health settings is required. Approaches need to be tailored to sector context and incorporate whole-of-organisation support inclusive of well-considered policies and procedures, commitment to ongoing monitoring and review, and access to the range of formal and informal supports.
- Investment in leadership through professional development, supervision, and mentoring approaches. Leadership support particularly for 'middle management' will be crucial to implementing workforce practice improvement.

- Expanded relationships with education providers to align supply with future demand is required. Collaborative approaches between vocational and tertiary education providers and industry must focus on ensuring training and education includes appropriate mental health and alcohol and other drugs content and that graduates have sufficient knowledge and practical experiences through placements that cover the breadth and depth of mental health service delivery.
- There are opportunities to support the range of primary healthcare and private providers to manage their waitlists more effectively and safely. As well as supporting providers in the private and primary healthcare sectors to adopt screening tools and other models to safely manage people while they are waiting for service. This would assist in reducing demand for acute mental health services in the public mental health system.
- Utilising the entire mental health workforce requires clarity on the components of care that meet the needs of consumers, the competencies required to deliver them safely and thus the vocational or tertiary qualifications and training required to obtain those competencies.

Recommendation 52: Support broader investment to address staff health, safety and wellbeing through consideration of changes to physical infrastructure, employment conditions, as well as workplace cultures.

Recommendation 53: Invest in leadership through professional development, supervision, and mentoring approaches whereby staff are identified early on in their careers and supported through a leadership pipeline. Development of a leadership program specific to the mental health and alcohol and other drugs workforce, which includes relevant content and tools to support the acquisition and maintenance of skills, knowledge and attributes required in contemporary mental health and alcohol and other drugs service delivery settings.

Recommendation 54: Work with tertiary education providers to ensure appropriate mental health and alcohol and other drugs content in curriculum and that graduates have sufficient knowledge and practical experiences through placements that cover the breadth and depth of mental health service delivery. This includes incentives for prospective hosts to create student placement opportunities across the range of mental health sectors and increased support to deliver training in regional areas and scholarship programs to train in specific fields such as disability, aged care, and alcohol and other drugs.

Recommendation 55: Provide incentives to undertake graduate programs in specific fields of study where there are known workforce shortages, such as disability, aged care, alcohol and other drugs, and mental health nursing.

Recommendation 56: Explore how newly emerged roles (such as Peer Workers and Aboriginal Torres Strait Islander Health Practitioners) could better interface and contribute to mental health care delivery.

Recommendation 57: Expand into previously untapped workforces (such as counsellors) through the establishment of mental health career paths and improved delineation and recognition of scopes of practice.

4.2 Harness the value of lived experience: peer workforce

- Peer workers are a relatively new, emerging non-clinical workforce within Australian mental health, alcohol and other drugs system through public and community service settings.
- Peer support workers specifically use their personal experiences of mental illness, alcohol and other drugs and/or suicidality; service use and healing/personal recovery to assist others. In the case of carer peer workers, they use their experiences of supporting someone through mental illness, alcohol and other drugs or suicidality; service use and healing/recovery to assist other carers[321]
- Peer workers come from a wide variety of backgrounds and have a range of skills, knowledge and life experience; providing a unique perspective and offering hope to individuals on their recovery journey by showing that recovery is possible. They may provide a range of supports including advocacy, community linking, and the provision of social, emotional and practical support322.
- Queensland Health reports the lived experience (peer) workforce is small accounting for 2 per cent of all mental health and alcohol and other drugs workforce, with 12.9 consumer worker FTE positions, and 4.4 carer worker FTE positions per 1,000 direct care FTE in Queensland[323].
- The Productivity Commission (2020)[324] identifies four key areas that have hindered the development and effectiveness of the peer workforce:
    - low recognition of the value brought by the peer workforce
    - inadequate supervision and support
    - poor professional development and career advancement
    - the absence of a professional representative body[325].
- The critical importance and value of the peer workforce in person-centred, recovery-oriented care has been highlighted in the *Fifth National Mental Health and Suicide Prevention Plan*[326], and a range of reports including the *Australian Productivity Commission Inquiry*[327] and the *Royal Commission into Victoria's Mental Health System*[328].
- Queensland is in a good position to optimise growing and supporting the mental health and alcohol and other drugs peer workforce in clinical and non-clinical settings. Developing and supporting a well-integrated peer workforce is identified as a strategic priority of the *Shifting minds: Queensland Mental Health, Alcohol and Other Drug Strategic Plan 2018-2023*.
- The recently released *Queensland Framework for the Development of the Mental Health Lived Experience Workforce*[329] and the National Mental Health Commission's *National Lived Experience (Peer)* Workforce *Development Guidelines*[330] both aim to provide employers guidance on assessing local readiness and prioritising activities that support the growth and development of the lived experience (including peer) workforce.
- Actions associated with the *Queensland Framework for Mental Health Lived Experience Workforce* include lawfully creating identified positions for people with a lived experience and advertising and appointing people who have a lived experience to those positions.
- There have been increasing calls for professionalisation of peer support worker roles, through for example, the establishment of national professional peak bodies for the lived experience workforce[331][332], as well as expanding training and qualifications for lived experience workers[333].
- Within Queensland, local and state-wide lived experience workforce networks established include *Peer Participation in Mental Health* (PPIMS), *Lived Experience Workforce Leadership Group* and *Queensland Lived Experience Workforce Network* (QLEWN). These networks are managed mostly on a voluntary basis, with limited resources when available.

- The *Certificate IV in Mental Health Peer Work* (Certificate IV), launched in Australia in 2012 was developed to meet the growing needs of the mental health peer workforce. This national qualification is designed for *peer support workers and carer peer workers.*
- A collaborative approach between Queensland training providers and the health and community services sectors is critical to ensure training is accessible, relevant, current and reflects the sector's needs; and that placements are available for students.
- As this is a national training package, consideration could also be given to approaching the national body, *Human Services Skills Organisation* to raise issues of quality, relevance, and supply
- Critically, any efforts to drive peer workforce development, professionalisation and training reform needs to be informed by the peer workforce, and people with lived experience considering entering this field.
- The ongoing growth and support of Queensland's peer workforce requires consideration of workforce planning, training, as well as supports to ensure:
    - workforce and service planning tools and frameworks include the development of a safe, supported lived experience workforce with stable employment
    - training is relevant, accessible and of high quality, and delivered by suitably qualified and supported experienced peer workers
    - there are opportunities for peer work students to find training placements, and ultimately employment in a range of government and non-government contexts
    - appropriate supports, including reasonable adjustments are in place to ensure safe, supportive working environments
    - there is opportunity for career advancement.

Recommendation 58: Develop a comprehensive state-wide strategy to grow, develop and sustain a diverse peer workforce, with consideration of clear career pathways. This includes funding across the sector (including NGO's) to enable permanent peer worker and leadership positions.

Recommendation 59: The health and community services industry skills advisory bodies and the peer workforce sector to work together to undertake ongoing reviews of the Certificate IV Mental Health Peer Work training.

Recommendation 60: Investment in the ongoing professional development for specialised peer worker roles such as suicide prevention, alcohol and other drugs, perinatal and infant mental health and so forth.

Recommendation 61: Development of programs that educate health professionals about the role and value of peer workers in improving mental health and alcohol and other drugs service delivery outcomes.

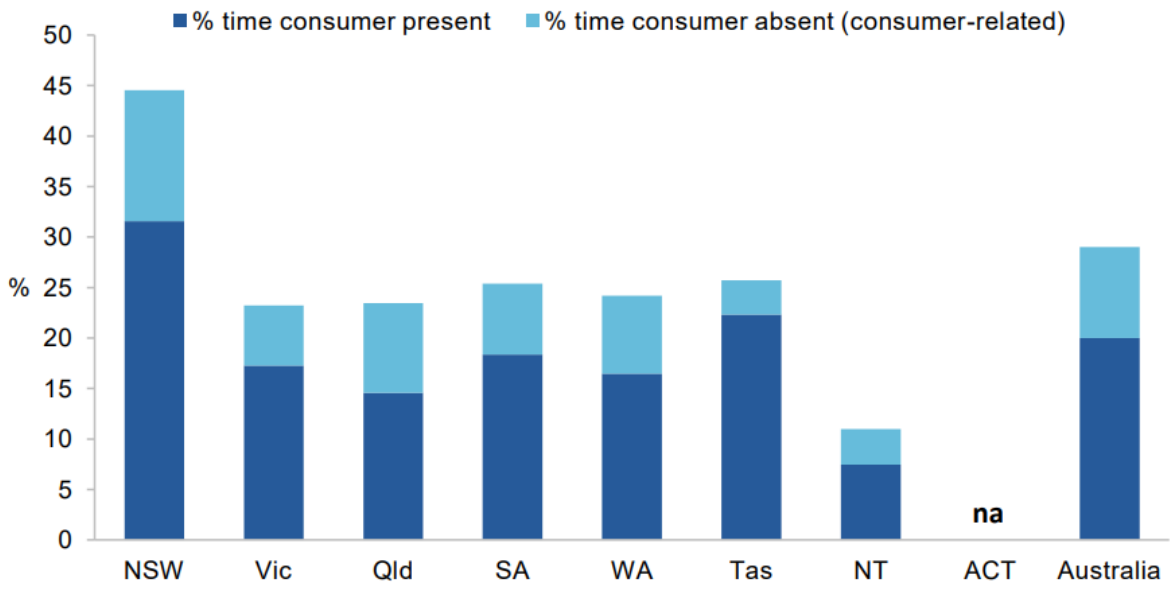
4.3 Optimise and adapt practices

- Given the considerable changes in mental health over the past 20 years, with increased service provision in the community, expansion of the non-government and private sectors, and greater focus on the role of primary care in mental health it is important to ensure practice reflects contemporary approaches and evolved service delivery landscapes.
- Challenges for mental health professionals including non-clinical and clinical roles have several main themes. These include high demand for services which leave limited time and space to focus on quality care, some professions unable to work to full scope of practice, organisational barriers that can stifle good practice, limited time to do vital collaboration and communication with

other providers and increasing knowledge requirements because of the complexities of mental illness and the diversity of populations being seen.

- Approaches to enhancing practice require a systemic approach incorporating agreement about what is considered best or good practice, development of resources and educational opportunities, guiding policies, procedures and frameworks, review of data and information to identify discrepancies across services and individual practitioners, uptake support in the form of supervision, mentoring and coaching and ongoing field research and knowledge translation.
- Currently there is confusion about which roles and sectors could be best deployed to provide case management (as opposed to care coordination). Jointly tested models of care would identify where there are overlays in roles and responsibilities and evaluate the effectiveness of current models of delivery. Longstanding models of case management and multidisciplinary treating teams need to be re-evaluated with respect to changed acuity and clinical presentations to ensure they are fit for purpose.
- Models of care need to be developed within sectors and tested across sectors to ensure that services are being delivered by the most appropriate workforce and that the interface between service providers occurs as seamlessly as possible.
- It is particularly challenging to implement strategies to enhance practice within particularly large, diverse, and devolved health systems. Change frequently depends on the drive of individuals rather than collective force and although there are some exemplars in certain areas, system-wide improvement is rare.
- Changes at the system-level are required to address the fundamental barriers and enablers of good mental health practice. This includes (but is not limited to): funding incentives to drive evidence- based practice, leadership development and support, education, and training mechanisms.
- Another contributing factor impacting the quality and safety of mental healthcare is that clinicians spend approximately 20 per cent of their time with consumers on average. The optimal proportion of time spent on providing direct care is proposed to be between 67 per cent of clinician time as identified in the NMHSPF[334]. It is further suggested that investment and replacement of the Consumer Integrated Mental Health and Addiction (CIMHA) application is required. This is in efforts to minimise staff time spent collective and documenting client information and clinical records and further enable information sharing across agencies through a modernised approach. **Figure 16** highlights the disparity in this productivity gap by jurisdiction.

Figure 16: disparity between the optimal proportion of clinical staff time spent on consumer-related activity[335]



- The cultural and linguistic diversity of the Queensland population has not only increased but evolved over the past several decades. Given the role that culture plays in influencing mental health it is critical for practitioners to recognise the relevance of culture to their practice.
- Existing accreditation and commissioning processes could be used to mandate the need for organisations to commit to adopting culturally responsive mental health practice frameworks and implement strategic priorities, rather than piecemeal actions.
- Cultural competency training alone is insufficient and ongoing supervision and mentoring is required to embed cultural capability. This includes dedicated placement opportunities in specialist multicultural services across sectors and expanded access to specialist supervision in this area.
- The impact of trauma on people who access mental health and alcohol and other drugs services can be profound. Increasingly, services are realising the effect that trauma plays on how consumers access and engage with services.
- Recognising the possibility of trauma in the lives of individuals who seek support and applying principles that minimise the risk re-traumatisation and promote healing are essential core components of services that are trauma informed. Adopting trauma-informed practices can improve engagement with individuals, treatment adherence and mental health outcomes.
- Existing accreditation and commissioning processes could be used to mandate the need for organisations to ensure alignment of all facets of treatment and care with the principles of trauma informed care through a quality improvement framework.
- As technologies evolve and consumers demand greater options in mental health, alcohol and other drugs treatments, care and support models, there will be a need for workforces to harness technology to improve outcomes. Digital mental health interventions have an essential role in supporting the closure of the treatment gap, providing mental healthcare, and enabling access to quality, timely and appropriate treatment within the home or as close to home as possible.
- The advancement of digital mental health services into the broader mental health landscape, notably since the onset of the pandemic, is rapidly transforming how mental health treatment, care and support are accessed and delivered.
- Digital mental health proposes an unprecedented opportunity to expand access to and availability of psychological therapies that are location agnostic[336], enable warm distancing to therapeutic support[337] and reduce barriers to treatment, care, and support, including overcoming stigma and discrimination.
- Growing evidence has demonstrated the clinical efficacy of digital mental health approaches, including internet cognitive behavioural therapy, in treating psychiatric conditions, reducing psychological and emotional distress, and promoting mental health and wellbeing.
- While digital mental health services are often presented as an alternative to traditional face-to-face treatments, there is growing evidence to support the use of such technology as a complementary approach to blended care. This enables both treatment enhancement and the extension of clinical services within and between sessions.
- However, such approaches must be evidence-based, integration and interoperation within the broader mental health context require further consideration, and the need for rigorous regulatory oversight, governance coordination, privacy and security, responsible and ethical use to ensure patient safety and quality of content is paramount.
- More than ever there is a need for practice models to incorporate collaboration with other sector service providers. Joint care planning and sharing of information must be supported through ‘live’ information platforms. To meet the holistic needs of individuals brokering services from across the range of social and human services will require innovation to the way mental health services currently operate.

- Governments need to incorporate funding and incentives to ensure widespread adoption of co-location models and shared information and care plans as core to the success of collaborative models. Increasingly health practitioners such as allied health and GPs are wanting greater knowledge sharing within and between professions and for greater availability of expert practitioners, particularly for phone and online consultations. Funding expansion of existing models whereby specialists such as psychiatrists can be accessed by GPs and other allied health are required.

Recommendation 62: Work with the Commonwealth Government to review and implement reforms to the MBS payment system to allow capacity to use expertise from other professions such as nurses and other allied health professionals to enable delivery of quality mental health and alcohol and other drugs care to people in primary healthcare settings.

Recommendation 63: Develop tools to help consumers find the right service provider, including the ability to view waitlists and other information relevant to people being able to make informed choices about providers. Additionally, support primary and private healthcare providers to use screening tools to manage waitlists more safely.

Recommendation 64: Mandate the need for organisations to ensure alignment of all facets of treatment and care with the principles of trauma informed and culturally responsive practice through a quality improvement framework.

Recommendation 65: Ensure funding and incentives to ensure widespread adoption of co-location models and shared information and care plans as core to the success of collaborative models. Implementation to be supported by protocols to ensure the effective, safe and efficient collection and sharing of information.

Recommendation 66: Implement a range of strategies to better support GPs and other primary healthcare providers. This includes access mental health education and training, programs that enable GPs to access specialist consultation with psychiatrists, allowing GPs to do rotations in public mental health services.

Recommendation 67: Support people to access online services and programs through digital literacy support and ensure ongoing evaluation and development oversight of online platforms.

Recommendation 68: Undertake an in-depth review and analysis of the existing non-client facing work that clinicians in the public sector are required to undertake to increase client facing time; identify and reduce administrative complexities; eliminate unessential tasks that detract from the care of the consumer; add costs to the health care system; and contribute to clinician burnout.

4.4 Safety and Quality

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

- Safety and quality frameworks and standards in mental health have been developed at national and state levels, including specific standards for community mental health organisations and digital mental health services.
- In particular, consumers, families and carers often identify the challenges of services meeting safety and quality standards where a person is involuntarily treated and where seclusion or restraint are employed.
- Compared to other jurisdictions, Queensland has one of the most contemporary mental health legislation instruments with identified safeguards, including Independent Patient Rights Advisers. Despite this, meeting safety and quality standards still appear to be complicated.
- Over the previous three years the Chief Psychiatrist Annual Report identified an ongoing increase in 'seclusion events'. Seclusion events are defined as confining a person at any time in an area or room from which exit is prevented and can occur up to three hours, or longer.
- To improve the quality and safety of mental health and alcohol and other drug services an individual's human rights need to be respected across the continuum of their treatment and care. For this to occur services will need to reduce the use of seclusion, restraint, and compulsory treatment.
- There is strong evidence the Safeward model has been very successful, the model identifies and addresses the causes of behaviours in staff and patients that may result in harm, such as violence and self-harm and reduce the likelihood of this occurring. Independent evaluations of the Safeward model highlight a reduction of seclusion rates of up to 36 per cent in adult wards and close to nil seclusions events in youth wards[338].
- Families and carers similarly identify that safety and quality standards are not met when engaging them in treating and caring for a loved one. For example, the decision to lock all acute mental health wards in general hospitals has also bought into question the quality and safety standards and how this decision impinges on an individual's human rights.
- The policy to lock all acute mental health wards (*Policy and practice guideline for Hospital and Health Service Chief Executives – Securing adult acute mental health inpatient units*) issued by Queensland Health in 2013 stated that authorised public acute mental health wards were to be locked across Queensland[339].
- This policy was issued under the previous Mental Health Act (2000) and has not been reviewed or updated since its initial inception.
- In December 2014, the Commission published its *Options for Reform: Moving towards a more recovery-oriented, least restrictive approach in acute mental health wards including locked wards* (Options for Reform: Locked wards)[340].
- The report highlights that international, national and Queensland policies and research indicate wards should be recovery orientated and least restrictive and, on this basis, the wards would start from a position of being open. This report outlined options for reform to support recovery—oriented practice and the implementation of least restrictive practices in acute mental health wards, with a particular focus on the role of locked wards[341].
- Since the Policy's implementation, and the publication of *Options for Reform: Locked wards; a range of legislative changes,* as well as emerging international research, a review of the Policy may be prudent. Additional factors for the review include:
    - The repeal of the *Mental Health Act 2000*, and passing of the Mental Health Act 2016
    - the Queensland *Human Rights Act 2019* (HRA) came into effect, and
    - Queensland's adoption to the *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*
- Recent research into locked wards found:

a) Locking the wards may be perceived to decrease absconding; reduce substance use in the wards; and reduce staff pre-occupation with monitoring the location of consumers. However, it remains a contentious practice with international research finding little evidence of reduced absconding from locked wards.
b) Disadvantages of locked wards for patients include lowered self-esteem and autonomy; negative perceptions of their safety and therapeutic environment; increased feelings of stigmatisation.
c) Locked wards are also associated with lower rates of satisfaction with services and higher rates of medication refusal[342].

- In its submission to the Select Committee the Royal Australian and New Zealand College of Psychiatrists, Queensland Branch (RANZCP Queensland Branch) outlines that tensions and risks in the blanket use of locked door policies in acute mental health inpatient facilities require striking a delicate balance between respect for human rights and autonomy, clinical utility and public and patient protection.
- The RANZCP Queensland Branch acknowledges the nuanced complexity of this policy directive but argues that any potential benefits in preventing absconding through locking all mental health inpatient facilities is outweighed by the adverse effects locked wards have on those detained.
- Additionally, the RANZCP Queensland Branch recommends that the Queensland Government review the locked wards policy for public mental health inpatient units, in light of human rights principles and international evidence.

Recommendation 69: Undertake an independent review of the locked wards policy for public mental health wards, in light of human rights principles, international evidence, and less restrictive contemporary best practice models.

Recommendation 70: Continue to enhance efforts to reduce the use of seclusion and restraint, with the aim of eliminating these practices, and ensure the Safewards model is embedded across all mental health and alcohol and other drug services.

Section 5: valuing and embedding lived experience

5.1 Build and foster lived experience leadership

- Queensland has a long history of consumer and carer engagement, participation, and leadership at various levels, including mental health advocacy, service delivery, service provider training, funding, planning and policy.
- In 1977, the Queensland Department of Health established the first *Office of the Patients' Friend*, to the establishment of mental health *Consumer Advisory Groups* (CAG) across several local health districts, and the subsequent establishment of the state-wide Queensland Consumer and Carer Advisory Group to provide advice, feedback and input into service planning, policy, and quality processes.
- There is growing literature and evidence globally of the benefits of co-design and/or co-production practices in mental health reform. Australian researchers are also emerging with local examples to demonstrate positive outcomes of system reform and mental health programs with lived experience participation and leadership.
- In response to the *National Standards for Mental Health Services*, specifically Standard 3 (Consumer and Carer Participation), Queensland Health developed the *Consumer, Carer and Family participation Framework* (2010).

- Over the next several years, local hospital districts started employing *Consumer / Carer Consultants* within the mental health settings to assist consumers (and their carers) and advocate on their behalf for service improvements.
- Queensland Health also developed a state-wide consumer and carer participation reimbursement schedule and the Commission developed a Paid Participation Policy to ensure that consumers and carers were adequately reimbursed for their time, travel and out of pocket expenses.

  - To assist public, non-government and private mental health and alcohol and other drugs services to improve and increase the engagement of people with a lived experience, their families and carers in service delivery, the Commission also developed *Stretch2Engage* (S2E)[343].
  - S2E calls for a different approach to how organisations think about engagement in that it places the responsibility for engagement on service providers, not on people using services. It sets the foundation for culture change, seeing lived/living engagement as core business.
  - In implementing S2E several factors impacted the sustainability of these improved engagement practices, including:
    - organisational culture and commitment
    - prioritising and resourcing engagement activity, and
    - embedding engagement systems and processes as part of business as usual.
  - In 2018 the Queensland Health Mental Health, Alcohol and Other Drugs Branch released the *Lived Experience Engagement and Participation Strategy* (*LEEP Strategy*).
  - The *LEEP Strategy* committed Queensland Health to engaging people with lived experience in state-wide policy and planning development activities across every level of the public mental health and alcohol and other drugs system.
  - The Final Report of the *Royal Commission into Victoria's Mental Health System* (2021)[344] discussed how the perspectives of people with lived experience are not being valued and given the priority; and the limited opportunities to truly lead, participate in meaningfully and promote change. The power imbalance is not only impacting methodologies of system reform, design, planning and implementation, but also make shifting mental ill-health recovery from `clinical' to `personal' on an individual level more difficult.
  - Developing leadership through the employment of identified lived experience positions at all levels (including executive positions) in mental health and alcohol and other drugs system reform is critical in embedding the lived experience lens across policy; service and program planning, design, and delivery; and evaluation.
  - Lived experience peer organisations have been agents of change in the mental health, alcohol and other drugs and suicide prevention sector in Queensland and Australia for decades. In 1988 Queensland was one of the first states to establish a lived experience organisation representing people who use drugs. This organisation continues to operate today.
  - The key findings of a project undertaken by the Queensland Network of Alcohol and other Drug Agencies (QNADA) on the need to establish an alcohol and other drugs peer peak found that:
    - the population of people who use drugs in Queensland is heterogeneous, and they represent the breadth of diversity of society.
    - the benefits of engaging service users (and potential service users) in service system planning and development are well established. However, there are significant barriers to engaging people who have a lived experience of problematic substance use with adequate representation across the diversity of the population, and
    - the criminalisation of the use and possession of illicit substances, and the stigma and discrimination faced by people who use drugs, acts as a significant barrier in the engagement and participation of these populations.
  - In recent years, lived experience has also emerged as a significant innovation in suicide prevention. Again, Queensland is a leader in this area with the establishment of the non-

government organisation *Roses in the Ocean* in 2008. *Roses in the Ocean* is Australia's leading lived experience of suicide organisation, with lived experience suicide prevention initiatives locally and nationally.

- Additional local and state-wide lived experience workforce networks have also been developed over time to support people with a lived / living experience and carers such as *Peer Participation in Mental Health* (PPIMS), *Lived Experience Workforce Leadership Group* and *Queensland Lived Experience Workforce Network* (QLEWN).
- The Commission currently auspices the establishment of the *Mental Health Lived Experience Peak Queensland* (MHLEPQ), building on initial scoping work undertaken by Queensland Health with support of Health Consumers Queensland. The MHLEPQ main focus is to:
    - provide policy advice and system advocacy to represent the common interests of Queensland public mental health consumers of all ages.
    - bring emerging issues to government for consideration, and
    - empower–through training, mentoring and support–individual consumer representatives to provide their perspectives and experiences on state-wide mental health policy and planning issues.
- This is the next step in a long journey to give people with a lived experience independent and meaningful input and engagement at every level and across all aspects of mental health in Queensland.

Recommendation 71: Encourage organisations and services to further develop and implement lived experience led co-design frameworks (i.e., S2E) to enhance meaningful lived experience led and trauma informed practice in policy design, system reform and planning, and service delivery.

Recommendation 72: Relevant human service organisations to establish lived experience identified positions to embed lived experience perspectives at all stages of the service delivery and policy cycles. This includes identified positions at the executive level.

5.2 Prioritise families, carers, and support people

- The *Carer Recognition Act 2010* defines a carer as someone who provides personal care, support and assistance to another individual who needs it because they have a disability, medical condition, mental illness or are frail and aged[345].
- The Queensland Carers Advisory Council is established under the Act to provide advice to the Minister for Seniors and Disability Services and Minister for Aboriginal and Torres Strait Islander Partnerships on work to promote the interests of carers and make recommendations to support carer recognition.
- Informal carers perform a fundamental role in caring for people with mental illness in Australia, providing a substantial number of hours of unpaid support, including practical tasks, emotional support and psychosocial care, and activities of daily living[346].
- It is estimated that 11 per cent of Australians will become an unpaid carer at some point in their lifetime. In Queensland, approximately 10 per cent of people are carers, of whom 11.5 per cent are aged under 25 years[347].
- In 2018, about one quarter of primary mental health carers only needed to provide care during periods or episodes when the care recipient's condition deteriorated (ABS 2020b[348]).
- It is well acknowledged that system and structural complexities, service gaps, barriers to access and complex navigation have resulted in a high proportion of people with lived experience unable to access quality, timely and appropriate treatment, care and support close to home and in their communities.

- Carers have become the de-facto frontline of service delivery. The absence of such care would result in poorer outcomes for people with mental illness, alcohol and other drugs issues and suicidality, with care needs going unmet or required to be picked up by formal health and social supports at additional cost[349].
- The annual national cost to replace this care with paid staff was conservatively estimated in 2018-19 was approximately $15 billion[350]. A compounded figure when considering the mental health-related expenditure in 2018-19 totalled $10.6 billion[351].
- In recent years there have been key shifts in care, treatment and support that recognise the importance of carers, families, and other support people, and aim to embed them as partners in the recovery of the person they care for.
- The Australian Minister's Advisory Council endorsement in 2013 of a *National Framework For Recovery-Oriented Mental Health Services* has seen increasing movement towards personal recovery approaches. This shift recognises the importance of considering a person within their social contexts and the important role that family, carers, and community play in recovery.
- Queensland Health's *Connecting care to recovery* has a key focus on supporting increased engagement of individual, families, and carers through a range of mechanisms. This has resulted in the Hospital and Health Services in Queensland employing carer peer positions to provide strategic, planning and community support to carers.
- To improve families and carers involvement of mental health services there is a need for the *Australian government to amend the Medical Benefits Scheme to provide rebates for family and carer consultations. Including options of flexible treatment and therapy options, accessing psychologist and therapist without a Mental Health Care Plan and the eligibility criteria for the Carer Payment and Care*r Allowance to reduce barriers to access for mental health carers[352].
- *Shifting minds* and *A Practical Guide for Working with Carers of People with a Mental Illness* reinforces the importance of system, provider, carer, and consumer collaboration to enhance the best outcome of a person's recovery and to prevent prolonged or life-long psychosocial disability, disadvantage, and dependence.
- Despite the increasing recognition of carers in person-centred care, carers themselves are an at-risk group in experiencing stigma and discrimination, diminished mental health and wellbeing, physical health issues, low confidence, financial insecurity, disruption to employment and education, and isolation from family, friends, and the community. These factors increase the risk of negative social, educational, economic and health impacts on carers and the people they care for.
- The symptoms and unpredictable episodic nature of mental illness can sometimes strain relationships, and this can make providing support more difficult and stressful. Many carer agencies have highlighted the need to provide funding in 'respite' activities to support carers to maintain their caring role.
- One study found that carers experienced clinical levels of depression at a rate 1.8 times higher than the general population due to stress (**table 3**)[353].

Table 3: The emotional and mental effects of caregiving[354]

	Primary carers of people with:[a,c]					
	mental illness (main condition)	*mental illness (secondary condition)*	*other behavioural or cognitive conditions*	*physical conditions*	*All carers*[b]	*Not a carer*[b]
	%	%	%	%	%	%
Kessler 10 indicator of psychological distress:						
Low distress level	32	38	46	54	53	60
Moderate distress level	25	29	29	26	23	21
High distress level	24	18	16	14	13	12
Very high distress level	19	14	9	7	10	7
Effects explicitly attributed to caring by carers:						
Had a stress-related illness	20	17	12	8	..	..
Feels weary or lacks energy	53	43	47	31	..	..
Feels worried or depressed	43	37	33	22	..	..

- In the *Becoming Visible* research conducted in Queensland by ARAFMI with 88 per cent carers being mothers and 68 per cent without a NDIS package, 95 per cent of the group feel tired and 73 per cent feel invisible due to lack of consistent practical and financial support[355].
- The transition to NDIS has reduced access to psychosocial supports for ineligible people and may be contributing to an increased demand for informal care.
- It is paramount the diverse needs of carers are taken into consideration, with some carers particularly vulnerable and missing support, including:
    - Aboriginal and Torres Strait Islander carers and carers from CALD backgrounds are less likely to be supported due a lack of culturally capable services or awareness of services, and cultural norms about family responsibilities and stigma about mental illness
    - LGBTIQ+ carers who may experience additional difficulties in the healthcare system if staff do not recognise or support their relationship, and
    - young carers who may not be taken seriously, are not aware that what they do is different to other families, are fearful of the family being broken up, or being exposed to stigma and bullying[356]
- In 2014, it was estimated that approximately 5 per cent of children aged 9-14 years provided care to a family member living with mental ill-health[357].
- The Queensland Government funds a range of carer agencies including ARAFMI, Kyabra, Wellways and Carers Queensland to provide advocacy, respite, support (phone, online and practical), service navigation and education to carers and families individually and in group format. However, it is recognised there are gaps in the service system that still need to be addressed and an independent mental health carer peak could inform system reform.
- Additional funding for these carer agencies would enable supports to reflect the diverse needs of carers and to be able to be more proactive in providing supports.

- Funding to build and strengthen opportunities for lived experience leadership of carers, in policy, program and service design and delivery, as well as evaluation, would enable reform to reflect the needs of carers, families and other supports in the care, treatment and support needs of the people they care for.

Recommendation 73: Establish an independent mental health carer peak to enable families and carers to meaningfully provide policy advice and systems advocacy.

Recommendation 74: All government, non-government and private sector agencies to build workforce capacity to implement family and carer inclusive practices that reflect diverse carer needs.

Recommendation 75: Increase investment in emotional and therapeutic support for carers, including respite, to assist carers to maintain their caring role. These supports must take into consideration the diverse needs of carers and ensure they are accessible for all carers.

Recommendation 76: Fund programs to assist carers to continue to participate in the workforce, and opportunities for carers to enter the workforce.

Section 6: Research, innovation, and system learning

6.1 The importance of monitoring, evaluation, and knowledge translation

- The mental health needs of a population change over time. Both the interventions to meet these needs, and the systems that deliver the interventions, should continually evolve with research and innovation.
- The research continuum spans basic biological, psychosocial, and social research into the causes and risk factors that impact mental health; epidemiological research into the prevalence and distribution of risk factors and mental disorders; prevention, treatment and recovery interventions for populations and individuals; and research into service system performance.
- A contemporary and future-oriented mental health system needs to be adequately supported and enabled through robust evidence base informed by evidence from across the research continuum and create the conditions where improvement and innovation are enabled.
- Monitoring, evaluation, and research are critical to ensuring system performance and oversight, accountability, improved policies, programs, and service delivery responses grounded in the outcomes that matter to people with lived experience, their families, carers, and support people.
- Enabling this requires understanding and responding to the system complexities and dynamics, clarifying areas of focus, identifying the critical leverage points for systemic change, and facilitating a culture of meaningful engagement, connection, participation, learning, and responsive adaptation informed by and commensurate to population needs and outcomes.
- A contemporary and future-oriented system must enable ongoing learning, innovation, reflection, and adaptation[358]; this requires:
    - building and supporting the culture and capabilities needed to encourage collaboration, innovation, and reflection
    - building the capability of people with lived experience, professionals, policymakers, and service providers to assess, analyse and undertake research and evaluation

    - bringing together multidisciplinary experts, researchers, service leaders and people with lived experience to undertake, translate and disseminate knowledge and research
    - supporting collaboration and innovation, and
    - enable collection, combination and sharing of evidence, including lessons learned to inform continuous quality improvement in the planning, policymaking, funding, service design and delivery, experiences, and outcomes.
- Queensland has solid foundations, particularly mental health research; our approaches must be strengthened to support translational research within and across sectors.
- Whilst the engagement and participation by people with lived experience, their families, carers, and support people in research are known, further is required to ensure that this is prioritised and meaningfully enabled.

Improving current approaches

- Embedding quality improvement methods to continually enhance interventions delivered by service systems, and maximising data collection, sharing, and use are critical[359].
- Whilst it is evident that there is much data collected at both national and jurisdictional levels, gaps remain and better use of needs to be made of data that is collected to ensure effective monitoring, evaluation, and research to inform decision-making, prioritise investment, drive systemic reform through innovation, and improve outcomes.
- At present, datasets are underutilised for several reasons, including:
    - restrictions on access and use
    - data collected may be of low quality and unsuitable for further analysis, and
    - some datasets in isolation may provide insufficient information to guide decision-making and reform[360].
- The significant potential for data linkage to improve data analysis is well evidenced. Data linkage techniques can improve datasets by extracting more information from existing systems361.
- As highlighted by the *Productivity Commission Inquiry into Mental Health* (2020)[362], better use of data linkage could enable the more in-depth assessment and understanding of:
    - time-series consumer and carer outcomes
    - cross-sectoral relationship of service use and associated outcomes
    - the social determinants and predictors of mental ill-health, and
    - consumer pathways of care.
- Addressing the gaps in data is critical to optimising our system. Such gaps in data include:
    - outdated prevalence and service use data – noting the findings of the *Intergenerational Health and Mental Health Study* are to be released in June 2022
    - mental health services provided by NGOs and MBS-related providers, including activity and performance
    - diverse demographic groups, and
    - non-clinical sectors[363].
- However, the paucity of datasets should not prevent action on mental health reform; instead, where evidence is available, action should be taken.
- This should be underpinned by collecting evidence that would support ongoing quality improvement. There is a need to continue to focus on testing innovative approaches and translating evidence into policy and scaled-up interventions.

Strengthening monitoring and reporting

- Optimising current system performance further requires the strengthening of monitoring and reporting.
- Whilst the importance of person-centred outcomes-focused system monitoring is well understood, our current approach remains limited, particularly regarding a clear focus on consumer and carer outcomes and the need to strengthen monitoring cross-sectoral approaches and outcomes.
    - Furthermore, as highlighted by the Productivity Commission (2020)[364], monitoring expenditure is vital in assessing efficiency to alternative allocations, and there is considerable scope to expand routine reporting of expenditure to account for cross-sectoral investment. This would enable:
        - a complete understanding of expenditure within and beyond the health sector
        - better support whole-of-government, cross-sectoral planning, integration, and coordination
        - improved understanding of the progress of mental health and wellbeing reforms, including service quality and outcomes
        - enhanced cross-sectoral accountability through increased transparency, and
        - oversight of whole-of-system performance regarding mental health and wellbeing[365].
    - Improving data availability, monitoring, reporting and oversight at the local and regional levels is critical for informed service planning, commissioning, integration, and coordination, and ensuring service decisions are correspond to population needs.

The importance of an evaluation culture

- Measuring outputs or comparing mental health expenditure alone provides no insight into achieving the best outcomes for people or provide evidence for a future course of action.
- Monitoring and reporting, in isolation, is insufficient to drive system learning nor sustained improvements; instead, should be matched by a robust evaluations system. Good evaluations can:
    - generate valuable information on investment, policy, program and service effectiveness and efficiency
    - inform continuous improvement
    - drive better outcomes for people with lived experience, their families, carers, and support people, and
    - promote accountability through enhanced transparency[366].
- Nationally, our approach to program evaluations in mental health is, in the main, ad-hoc, uncoordinated and lacking objective evidence[367].
- The Commission shares the view of the Productivity Commission (2020)[368] and the Royal Commission (2021)[369] that achieving continuous improvement requires program design, implementation, and service delivery evaluations.
- The Commission recommends that the Queensland Government sets an expectation that adequate evaluation is a condition of funding for all programs, initiatives and innovations, and this expectation extends to the sharing of evaluation findings to support broader system learning.
- Consistent with the findings of the Royal Commission (2021)[370], reflective and evaluative practices within workplaces is critical.
- To support and enable people with lived experience and professionals to undertake research and evaluation, they need access to knowledge, capabilities, and support to measure and assess new approaches to consumer experiences and outcomes.

Building on solid foundations

- It is acknowledged that Queensland has solid foundations, particularly in mental health research, innovation, evaluation, and knowledge translation. For over 30 years, the Queensland Centre for Mental Health Research (QCMHR) has demonstrated a capability, domestically and internationally, as a leader in mental health research. The work of QCMHR includes basic science, epidemiology, clinical trials, and mental health service planning with the goal of reducing mental ill-health within the community.

Recommendation 77: Consolidate the role of QCMHR through increased investment to:

- administer a dedicated mental health evaluation and innovation fund
- establish and promote collaborative networks across the state to drive and facilitate innovation
- lead translational research to inform service delivery, policy and planning, and
- provide support, including research, evaluation, and knowledge translation, within and beyond Queensland Health

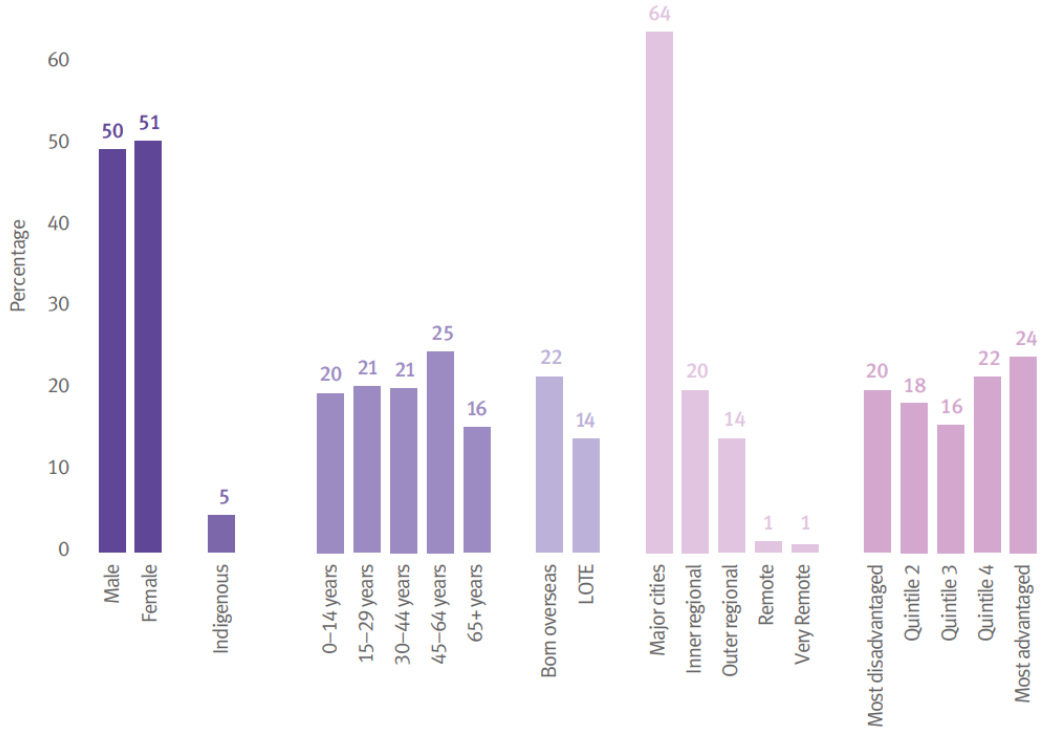
Section 7: a final note

- Mental health and alcohol and other drug reform are primarily about the required system changes. These changes are required across health, government agencies and sectors, and across levels of government. System change is not just about additional programs, services, and funding - even though these are vital ingredients to achieving system change.
- System change needs to begin with a clear agreement and definition of roles and responsibilities for mental health, alcohol and other drugs and suicide prevention between the Federal and State governments in the areas of policy, funding, and service delivery. Building on solid foundations, it also requires strengthened cross sectoral accountabilities at the State level.
- It also needs to be underpinned by a substantial increase in investment in the public and non-government sector services and supported by improvements to the primary healthcare system. There should be a strong focus on building a new community front door for all metal health and alcohol and other drug needs. This new and broader community front door needs to provide access to crisis response, early intervention, and the range of treatment and supports. It must also operate to connect people with the right services to meet their holistic needs.
- System reform in the alcohol and other drug sector must begin with a clear policy shift that diverts people to early intervention and health responses rather than criminal justice responses in isolation. This shift needs to be accompanied by a significant enhancement in alcohol and other drug services across Queensland, particularly in the areas of treatment and harm reduction.
- There will continue to be growing demand for services necessitating more and more investment unless we start to develop an investment and outcomes plan for promoting wellness, preventing illness, and intervening early, particularly in the early years, and in schools, workplaces, and the broader community.
- The required system change will only yield the required outcomes if it is informed and led by people with lived experience and their families and carers.
- To achieve system, change there needs to be a suitably skilled and capable workforce, in the numbers required to meet demand, distributed equitably across Queensland, and is appropriately supported to deliver contemporary mental health and alcohol and other drugs services.
- Evidence, data, and research needs to underpin the proposed system change. Queensland will need to enhance its capacity and capability in translational research and information management to inform policy, practice, and funding approaches.

Appendix 1: a growing and diversifying Queensland

- Our people are our most important and valuable asset[371]. Queensland is a highly diverse state and has the third-largest population in Australia, representing 20.3 per cent (5.2 million) of Australia's overall population[372]. The median age of Queenslanders is 37.8 years, and our population is ageing[373].
- At the time of the 2016 Census of Population and Housing, 4.6 per cent of Queensland residents identified as Aboriginal and Torres Strait Islander origin (221, 276 persons)[374]. The Aboriginal and Torres Strait Islander population is relatively young, with a median age of 22.0 years, compared with the non-Indigenous population's 37.8 years[375].
- Net interstate migration comprised the largest contribution to population growth in Queensland in the 12 months to 30 June 2021 (67.4 per cent). This was followed by a natural increase (63.9 per cent) and net overseas migration (–31.3 per cent). In addition, the COVID-19 pandemic and the resulting closure of international borders have impacted net overseas migration[376].
- Queensland is the most decentralised state compared to other Australian jurisdictions[377]. Our regional, rural, and remote communities are great places to live, and each community is unique.
- Reforming Queensland's mental health and wellbeing system requires an understanding of the diverse nature of the Queensland community. **Figure 17** provides an overview population characteristic in Queensland. The following provides an overview of the Queensland demographics, including service gaps and needs across diverse groups and communities.

Figure 17: an overview of population characteristics, Queensland, 2018[378][379]



1.1. Regional, rural, and remote Queensland

- Queensland's regional, rural, and remote communities face specific mental health challenges, including higher rates of suicide and mental illness and limited access to services and supports.
- These challenges are exacerbated by skills and workforce shortages in mental health, which vary depending on the funding and resources provided by State and Federal Governments. This means that there are often workforce and specialist mental health-skills shortages in some regions while others are adequately resourced.
- There are a range of additional issues and barriers to accessing services for people living in regional and remote areas. These include the remoteness of some communities requiring people to travel long distances to access services, which can be exacerbated by a lack of community infrastructure such as public transport.
- Both telehealth and digital mental health solutions have been in use in Queensland previously and re-emerged during the COVID-19 pandemic as a solution to support health service delivery and reduce face-to-face contact.
- Tele-health solutions have been identified as solutions to the disparate access to care experienced by regional and remote communities. However, technological issues can impact the accessibility of tele-health services for people living in rural and remote areas and may not be appropriate in all circumstances.
- Tele-health services should not replace face-to-face treatment but instead complement existing face-to-face services.
- There are also significant issues for health services recruiting to positions in rural and remote areas, particularly for specialists. This can result in regional areas having high turnover rates in clinicians and/or long periods of unfilled positions.
- Stakeholders have called for governments to collectively develop a national plan to increase the number of practising psychiatrists, psychologists, and mental health nurses in the regions where they are needed most. This must be supported by increasing the availability of supervision for trainees, with a focus on sub-specialties and localities where there are substantial shortfalls.
- Most people who are in a mental health crisis or who are experiencing distress do not need to see a psychiatrist and may instead require the support of a clinician with specific mental health training and experience. There are opportunities to enhance the availability of nurses and nurse practitioners with specific mental health training and experience to fill this service gap.
- For Aboriginal and Torres Strait Islander peoples, there are calls to enhance the understanding of social, emotional and cultural wellbeing as distinct from mental health. Services should recognise this distinction and consider expanding accessibility and availability of trained Aboriginal and Torres Strait Islander health workers.
- There are also opportunities to enhance existing infrastructure and local networks to better support people in distress beyond a purely health system response. This may include improving existing community responses through neighbourhood centres to support people in crisis without requiring a clinical response.
- Social and cultural barriers can also affect the level of understanding service providers have about local cultural issues and make it difficult for clients to build trusting relationships. This includes issues such as perceived stigma, a feared loss of privacy and confidentiality in small communities and impacts from the turnover of mental health workers.
- Beyond general measures to strengthen the mental health workforce, there are opportunities to enhance the integration, coordination and funding of services between Commonwealth, State and

regional agencies to better integrate existing services. There are opportunities for all levels of government to collaborate on the planning, commissioning, implementation and evaluation of services to deliver more targeted and effective services.

1.2. Children

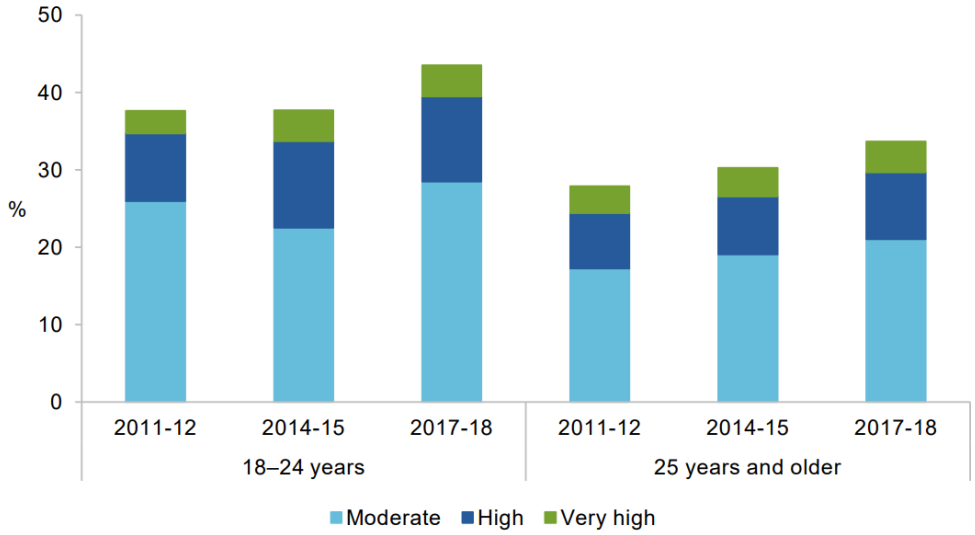
- As is well evidenced, a child's social and physical environment, including before conception, are the key determinants of mental health and wellbeing across the life course[380].
- Early childhood provides a critical and fundamental window of opportunity to shape a child's holistic development trajectory and build the foundation for their future[381].
- To enable and empower children to reach their full potential, they need access to quality healthcare and nutrition, protection from risk and harm, a sense of security and attachment, positive and nurturing family environments, opportunities for early learning and responsive caregiving[382].
- Maternal and paternal factors are essential, including during the periconceptional period. Supporting mothers and fathers before, during and after pregnancy and promoting an optimal environment for healthy development is critical for healthy growth and development[383].
- The continual growing body of evidence shows that experiences can have life-long consequences for health and wellbeing during this period.
- Good social and emotional wellbeing in children means that children can feel safe, happy, heard, supported and have meaningful and loving connections with family, friends and their broader community[384].
- In 2018, approximately 980,000 children aged 0-14 years in Queensland, comprising 19.6 per cent of the total population, and about one-third (34 per cent) of Aboriginal and Torres Strait people were aged 0-14 years[385].
- Mental ill-health often starts early in life and persists across the life span, with significant onset during adolescence and young adulthood. In any given year, 1 in 7 children and adolescents will experience a mental disorder, with an estimated 50 per cent of adult mental illness beginning before the age of 14 years[386].
- While several factors contribute to the experience of mental ill-health, the impact of Adverse Childhood Experience (ACEs) on the development of mental ill-health is well evidenced.
- Experiences including family and domestic violence, parental/caregiver mental ill-health or problematic alcohol and other drugs use, child abuse (physical, emotional or sexual) or neglect, family instability due to parental separation, divorce or incarceration, poverty and socioeconomic disadvantage, housing, income and food insecurity, and ongoing effects of racism can compound the impact of ACEs[387].
- According to *Voices of Hope: growing up in Queensland Survey 2020* (Queensland Family and Child Commission 2020), young Queenslanders viewed their communities positively and were hopeful for the future. However, survey respondents identified mental health, environmental protection and quality of education as issues of critical importance for young Queenslanders[388].
- Prenatal and perinatal health and mental health services, schools and preschools are well placed to support the social and emotional development and wellbeing of children and young people. However, there are significant gaps in service provision and policy coordination, across the early lifespan, from prenatal mental health and wellbeing, including support for parents, families, and children. For example, for children aged under 12 years, there is no "system" of affordable, integrated care that is commensurate to need[389].

- Programs that support the specific element of infant and childhood social and emotional wellbeing development do not reach all families who require such support or are inconsistently implemented on the ground.
- Furthermore, families experiencing significant and complex needs often face difficulties engaging the appropriate supports, including multi-agency supports, that are conducive to need. The Australian Government (2021) highlighted that the onus of navigating such complexities should not sit with the child and their family, carers, or support people[390].

1.3. Young people

- The life stage of youth, commencing from puberty and through to the transitional stages of early adolescence and young adulthood, is both a critical and fundamental developmental period to optimise personal growth and development[391].
- Children and young people are uniquely vulnerable and heavily impacted by the onset of mental ill-health due to complex biological, sociological, and environmental reasons[392][393].
- Adolescence and early adulthood are dynamic structural and functional changes in the brain driven by maturational processes.
- The transition from childhood to independent adulthood presents new and emerging developmental challenges against the highly dynamic changes in brain architecture[394]. It is a period characterised by the development of individuality, autonomous identities, independent social networks, and intimate relationships[395]. In addition, education, training, and employment factors can further contribute to the experience of mental health challenges but can further confer the benefits required for future social and economic participation.
- In Queensland, there are over 1.02 million young Queenslanders aged 15-19 years, comprising 20 per cent of the population[396].
- Across the lifespan, children and young people aged between 10-14 years bear the significant burden for the onset and impact of mental ill-health.
- Approximately 75 per cent of adult mental health disorders emerge by the time people are 25 years[397] and are the leading cause of disability[398]. It is estimated that 26 per cent of young Australians aged between 18-24 years will have experienced a mental health condition[399], and suicide remains the leading cause of death for people aged between 15-24 years[400]. **Figure 18** provides an overview of psychological distress in young people over time[401].

Figure 18: psychological distress in young adults over time[402]



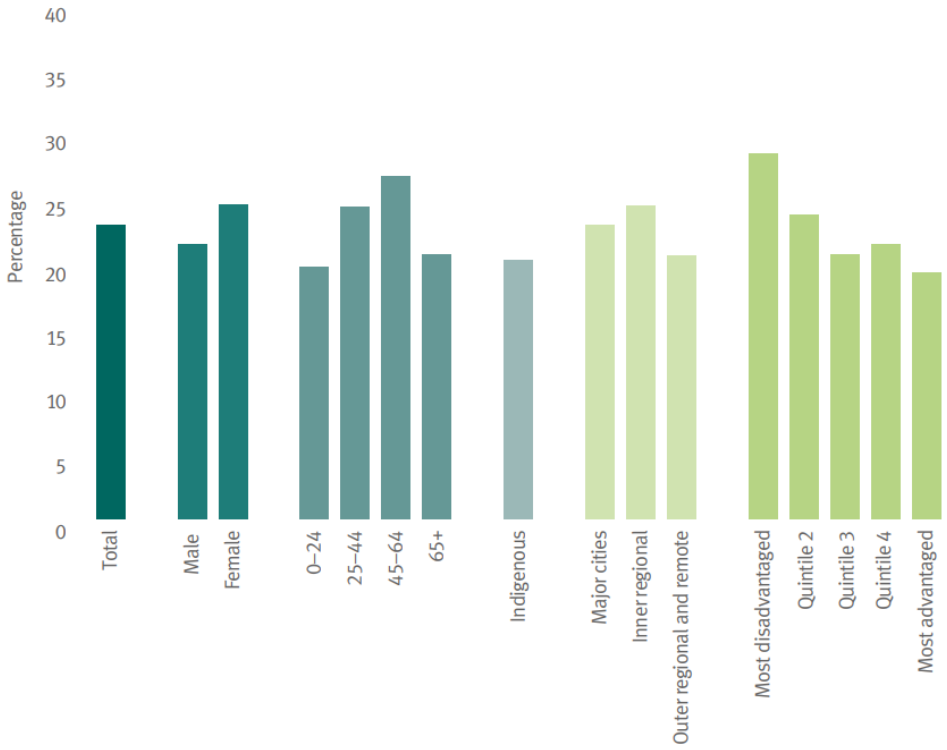
- Mental illness can substantially impact the life trajectories of children and young people. While most young people experience positive mental health and wellbeing, mental ill-health is the leading cause of disability for people aged 10–24 years[403]. By Year 9, students with mental illness may be up to five years behind students who do not have a mental illness[404].
- The high overall engagement rate of young people, e.g. in education and training, conceals that young adults are more likely to be unemployed than the general population. Moreover, young people often work in precarious forms of employment, vulnerable to economic impacts through, for example, the COVID-19 pandemic[405].
- This further contributes to the experience of stress and distress, social and economic exclusion, and reduced wellbeing, and may be less likely to seek support with strategies for re-engagement in work or study remaining inconsistent[406].
- In addition, several groups of students may be at additional risk of mental ill-health due to the experience of societal inequities. These include Aboriginal and Torres Strait Islander young people, LGBTIQ+ young people, young people from low socioeconomic backgrounds, regional and remote areas, young people with disability, and young people from culturally and linguistically diverse backgrounds, including young people from culturally and linguistically diverse from refugee backgrounds.

1.4. Younger and middle-aged adults

- In the main, the period between 30-64 years is predominantly focussed on employment, job opportunity and job security, finding and obtaining safe, affordable, and appropriate housing commensurate to need, consolidating social networks, establishing, and nurturing long-term relationships, raising children or caregiving, and planning for retirement[407].
- In 2018, approximately 2.25 million Queenslanders aged 30-64 years, represented approximately 45 per cent of the total population. In 2020, around 85 per cent of adults considered themselves to be in excellent, good or very good health[408].
- In 2017-18, more than one-in-five (23 per cent) Queenslanders self-reported long-term mental health or behavioural problem, higher than the national average of 20 per cent (one-in-five adults) [409].
- Compared to previous years, the proportion of self-reported mental health and behavioural issues have doubled since 2001. However, this may indicate increased awareness, reduced stigma and increased help-seeking behaviour[410].

- Figure 19 provides the proportion of persons with self-reported mental health and behavioural problems across gender, the life course, socioeconomic status, across Queensland[411].

Figure 19: proportion of self-reported mental and behavioural problems, Queensland 2017-18[412]



- Whilst the burden of onset of mental ill-health predominantly affects young people before the age of 25 years, if left untreated, the impacts of mental ill-health may further influence other life domains, further reducing wellbeing, the standard of living and quality-of-life outcomes[413].
- During this period, pre-clinical health challenges may further manifest to clinical conditions. Mental health and physical health are inextricably linked and associated with overall wellbeing[414].
- People living with mental ill-health experience other health-related issues, including physical health, problematic alcohol and other drugs use, and other comorbidities, which can lead to poorer health outcomes and increase the use of healthcare[415] [416].
- Concurrent to providing efforts to promote mental health and wellbeing and prevent and reduce the impact of mental ill-health, problematic alcohol and other drugs use and suicide, it is critical that community-based psychosocial supports are provided, enabling wellbeing through access to timely, appropriate care.
- Mental health reform in this area is longstanding and has further been compounded due to the effects of COVID-19.
- People with lived experience, their families, carers, and support people have long advocated that the current system is highly complex, challenging to navigate and experience difficulties accessing the right level of treatment, care, and support at the right time, where it would be most beneficial.
- Despite significant investment and concerted efforts, this further contributes towards our current approach of a crisis-driven system that emphasises thresholds to services delivery, is highly fragmented and does not, in the main, respond to whole-of-person needs[417].

1.5. Older persons

- As family members, members of the community, volunteers and active participants in the workforce, older Queenslanders make fundamental contributions to the social fabric of our society.
- Initiatives that seek to facilitate independence, active participation in the broader community, ability to spend as much time in the home, close to family, friends and support networks is critical to supporting quality-of-life outcomes[418].
- In 2018, it was estimated that 770,000 people aged 65 years and older in Queensland. This comprised 15.4 per cent of the total population and is projected to increase to 17.3 per cent in 2026[419].
- In 2017-18, it was estimated that 35 per cent of Australians aged between 65-74 years living in single-person households, which increased to 52 per cent for persons aged 75 years and older[420].
- Approximately 70 per cent of Queenslanders aged 65-74 years lived in households without a mortgage, a figure that increases to 74 per cent for persons aged 75 years and older. Most Queenslanders in both age cohorts lived in households not engaged in the labour force[421].
- In 2017-18, there were over 49,100 people in residential aged care facilities in Queensland. In recent years, the mental health and wellbeing needs of residents, their families, caregivers, and support people have received increasing attention through the Royal Commission into Aged Care Quality and Safety[422].
- Good mental health and wellbeing are critical to healthy ageing, and older people require access to the full spectrum of mental health and wellbeing treatment, care and support, ranging from prevention to early intervention and clinical care[423]. Efforts to support good mental health for older people should:
    - promote independence, dignity and quality-of-life outcomes for the persons, their families, carers and support people
    - care must be informed by aligned with contemporary best practices in mental health aged care and disability services
    - care must be recovery-oriented, person-centred, are high-quality and safe, promote family and carer involvement and enablement
    - treatment, care and support liaison between mental health, social services and community providers should be facilitated to enable close coordination and continuity of care, and
    - recognition and respect for the roles and needs of older Aboriginal and Torres Strait Islander peoples with the full awareness that such concepts are integrated into broader social and emotional wellbeing[424].
- Whilst most older persons have good mental health and wellbeing, mental ill-health is common, with many at risk of developing mental health disorders, neurological disorders, problematic alcohol and other drugs use, and other physical health conditions, including diabetes, hearing loss and osteoarthritis[425]. However, it must be noted that often such conditions occur comorbidly.
- Factors that may increase the risk of an older person developing mental ill-health include:
    - physical health problems and conditions
    - chronic pain
    - side-effects from medications
    - grief and loss stemming from relationships, autonomy and independence, work and income, self-worth, mobility and flexibility
    - social isolation
    - significant changes in living arrangements
    - admission to hospital, and
    - anniversaries and the associated memories[426].

- The Royal Australian and New Zealand College of Psychiatrists (2019) state that there is a significant under-estimation of the prevalence of mental ill-health in older populations[427]. The ageing Australian population means that there will be a rapidly increasing demand for mental health treatment, care, and support for older people and older persons with longstanding mental health conditions.
- Current planning, funding and resourcing of mental health treatment, care and support services for the growing older population remains of critical concern.

1.6. Aboriginal and Torres Strait Islander people living in Queensland

- Aboriginal and Torres Strait Islander Australians are recognised as the oldest continuing culture in the world, with many diverse nations, cultures and languages and a history of over 60,000 years[428].
- At the time of the 2016 Census of Population and Housing, 4.6 per cent of Queensland residents identified as Aboriginal and Torres Strait Islander origin (221, 276 persons)[429].
- Aboriginal and Torres Strait Islanders people living in Queensland comprised nearly one-third (27.7 per cent) of Australia's estimated resident Indigenous population of 798,365 persons[430].
- Aboriginal and Torres Strait Islander population was relatively young, with a median age of 22.0 years, compared with the non-Indigenous population's median age of 37.9 years[431].
- Aboriginal and Torres Strait Islander peoples adopt a holistic concept of social and emotional wellbeing that recognises the importance of connection to land, culture, spirituality, ancestry, family and community, and how such connections have been formed and shaped across generations, and the processes by which they affect individual wellbeing[432]. Social and emotional wellbeing further recognises the impact of policies and past events upon wellbeing[433].
- Aboriginal and Torres Strait Islander people continue to experience health inequities across diverse health and wellbeing indicators within the context of colonisation, historical and intergenerational trauma, impacts of the Stolen Generations and removal of children, systemic racism, discrimination, economic and social disadvantage[434].
- Factors that are critical to and enhance the social and emotional wellbeing of Aboriginal and Torres Strait Islander people include connection to country, spirituality, ancestry and kinship networks, strong community governance and cultural continuity, renewal of Aboriginal and Torres Strait Islander culture and knowledge systems, and the capacity for self-determination[435] [436] [437].

1.7. Cultural and linguistically diverse communities

- Queensland is home to people from over 220 countries, speaking more than 300 languages and affiliated with over 100 religions[i]. One in five Queenslanders were born overseas and 11.2 per cent of the population spoke an overseas language other than English at home[1]. Queensland has become more culturally diverse over time and now has the third-largest overseas-born population in Australia[2].
- The social, economic and cultural benefits of a multicultural community can only be fully realised in an inclusive community, where there is an equitable approach to mental health service access, treatment and care.
- Cultural identity is a strong determinant of the barriers and enablers of mental health and wellbeing. Some individuals from culturally and linguistically diverse communities are

predisposed to a range of social, cultural and economic disadvantages that can increase vulnerability to mental illness. Particular cohorts including refugees and asylum seekers, international students, new and emerging communities and people involved in the criminal justice system face additional challenges in accessing and navigating the mental health service system.

- Culture plays a key role in determining how people and communities conceptualise mental ill-health thus influencing how individuals experience symptoms, how they might communicate those symptoms, and the pathways they take to get to services, as well as their expectations about treatment and how they engage with service providers. Understanding and responding to cultural needs is fundamental to achieving health equity for people from CALD communities.
- Individuals from cultural and linguistically diverse (CALD) communities have variable access rates to mental health and support services due to a number of barriers such as high levels of stigma, poorer mental health literacy, difficulties navigating the system, as well as a lack of culturally appropriate and culturally safe mental health service options.
- Cultural conceptions of mental ill-health and the recovery journey may differ across diverse communities, and services appropriately explore, respond and respect the diverse needs and experiences. Additionally, negative experiences, including racism, and discrimination, can further impact help-seeking, overall mental health and wellbeing, and limit social and economic participation.
- These barriers could be addressed as part of a systemic approach incorporating both dedicated funding streams for multicultural-specific services as well as culturally responsive mainstream services, programs across the continuum of care, and collaborative responses across whole-of-government.
- Service planning must account for culturally and linguistically diverse populations and consider the social, economic and cultural factors that relate to mental ill-health and service access. This includes adjustment to existing planning frameworks and flexibility to divert funding to innovative models of care or prevention and early intervention programs that can address current service gaps for vulnerable cohorts.
- Funded mental health, suicide prevention and alcohol and other drugs programs should include implementation of cultural competency standards and review and monitor progress towards culturally competent service delivery as part of funding contracts and regular quality improvement activity. This includes standards for a culturally competent workforce.
- Culturally appropriate models of care that can provide culturally safe and tailored wrap-around psychosocial and clinical mental health alcohol and other drugs treatment services need to be scaled up to enable equity of access across regional locations throughout Queensland, particularly in highly diverse areas such as the Gold Coast, Toowoomba, Cairns and Townsville.
- Increased access to the range of primary health providers who can work with interpreters and are incentivised to work in culturally responsive ways could be explored within the current MBS payment system.
- In addition to this, greater collaboration and partnership with sectors outside of health is needed to develop holistic and person-centred responses to the social determinants of mental health that are especially relevant to CALD communities, including the range of human and social services.

1.8. Lesbian, gay, bisexual, transgender, intersex, queer or questioning

- In 2016, an estimated 3.0 per cent of Queenslanders aged 18 years and older identified as LGBTIQ+.
- In the main LGBTIQ+ people live flourishing lives. However, multiple studies have demonstrated that a disproportionate number experience poorer mental health outcomes and have higher suicidality and self-harm rates than their peers; and experience higher likelihoods of stigma, prejudice, discrimination, social exclusion, homophobia, transphobia, stereotyping, ostracising and harassment[438][439][440][441]. Homophobic abuse experienced by young people is associated with problematic alcohol and other drugs use, self-harm and suicide attempts[442].
- Compared to the general population, LGBTIQ+ people are more likely to experience and be diagnosed with a mental health condition, are more likely to have engaged in self-harm in their lifetime, are more likely to have thoughts of suicide, and are more likely to attempt suicide[443].
- National evidence on the health and wellbeing of the LGBTIQ+ is reliant upon a limited but growing number of small-scale studies that seek to target the LGBTIQ+ population or part thereof. Whilst valuable, it is evident that significant knowledge gaps remain[444].
- Due to ongoing perceptions and experiences of stigma and discrimination can face barriers to mental health treatment, care and support. The *Fifth National Mental Health Plan* (2017)[445] emphasises that reducing stigma and improving the appropriateness of mental health services is critical for LGBTIQ+ communities.

1.9. People with disability

- Through *Everybody has a role to play – All Abilities Queensland*, the Queensland Government seeks to create an inclusive society where all people, including people with a disability, can reach their full potential and live flourishing lives. A Queensland where people with disability are respected for their abilities and have equal access to opportunities[446].
- In 2018-19, it was estimated that 19 per cent of Queensland were living with a disability. Approximately 285,000 Queenslanders living with a severe or profound disability imposed limitations on their core activities[447]. Nationally, it is estimated that 36 per cent of people with severe or profound disability had self-reported mood (affective) disorder, compared to 32 per of people with other forms of disability and 8.7 per cent of people without disability[448].
- People with disability are more likely to experience higher levels of distress, anxiety, or depression than people without disabilities, with people with intellectual disabilities are two to three times more likely to experience common mental disorders[449].
- Social factors of lack of access to work, including meaningful employment, inadequate housing, financial limitations or insecurity, and social exclusion, further compound the experiences of mental ill-health and psychological distress[450].
- Nationally, 75,000 people receive psychosocial support directly from other Australian, state and territory government-funded programs[451]. However, there is a significant gap in Australia's provision of psychosocial supports, particularly for those not receiving NDIS support.
- It is estimated that there are somewhere between 551,000 people with *significant mental illness* to 151,000 with *severe and persistent mental illness* who would benefit from psychosocial support, who are missing out[452].

1.10. Carers

- Carers, families and other supports are an essential part of a person's recovery journey. Informal carers perform a fundamental role in caring for people with mental illness and problematic alcohol and other drugs use in Australia, providing a substantial number of hours of unpaid support, including practical tasks, emotional support and psychosocial care, and activities of daily living[453].
- In Queensland, approximately 10 per cent of people are carers, of whom 11.5 per cent are aged under 25 years[454]. Overall, females were more likely to be carers than males with 12.3 per cent of all females providing care in 2018 and 9.3 per cent of all males[455].
- Approximately 7 per cent of Queensland carers identify as Aboriginal and Torres Strait Islander persons and a further 10 per cent are from culturally and linguistically diverse backgrounds[456].
- Over half of carers are not working or looking for work, with 6 per cent in paid full-time work[457].
- It is estimated that 11 per cent of Australians will become an unpaid carer at some point in their lifetime.
- Carers in their supportive role have touchpoints across a range of government and non-government agencies and services including the mental health system, primary health care, income support and disability including the NDIS, as well as for some the education, ambulance, police and the criminal justice systems.
- Navigating these systems can be very difficult, with often incomplete information available to carers in relation to their rights and options for their loved one. This can be exacerbated when their loved one is in crisis.
- The knowledge that mental health carers have about what is needed to shift the service system's response to mental health, alcohol and other drugs and suicide prevention is essential to genuinely person-centred, recovery-oriented responses.
- Carer involvement at all levels of planning, delivery and evaluation can lead to improved outcomes for individuals, families, the community and the system more broadly. It can also help to reduce stigma and harm.
- Carers themselves are an at-risk group in experiencing diminished mental health and wellbeing due to their role in caring for loved ones.
- Carers are constantly facing stress that come from financial hardship, family violence, homelessness, unemployment, poor physical health, cultural safety, and inaccessibility to education and training.
- ARAFMIs *Becoming Visible* research found most respondents reported experiencing high levels of stress, tiredness, loneliness and sadness, as well as significant rates of fear and anger.
- Two key areas of challenge and potential areas for improved responses were identified:
    - Carer wellbeing: Identified need for better access to counselling; regular, practical in-home support; selfcare/help workshops; closed Facebook group to share experiences; respite services for carers; improved quality of caring services and service providers.
    - System responses: Identified need for better financial support; better consistency in support for those being cared for; easier access to the mental health system.
- Accessible, cultural appropriate and affordable health care, enter, remain and returning to employment support, higher carer subsidies and welfare system, and flexible and affordable learning are crucial to enable carer's daily roles and responsibilities.

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Implemental
Wellbeing Capacity Building Project managers and champions
Wheel of Wellbeing (WoW) Practitioners
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PROJECT HIGHLIGHTS

Individuals exposed to WoW thinking and practice have an increased understanding of the science behind health and wellness. They also report increased awareness about, and participation in activities which support their health and wellbeing.

Organisational cultural changes related to health and wellbeing are evident as a result of implementation of the WoW framework. This includes embedding WoW thinking and practice into organisational governance, policies, and service delivery.

Systems level practice changes have been generated through strategic use of the WoW framework as a collaborative planning and service delivery tool. Strategic engagement of key sectors has also facilitated further uptake of the WoW across the community, health and education sectors.

Adaptation of the WoW specifically for the education sector and strong advocacy by WoW education champions has facilitated uptake of the WoW framework at a systems and individual school level.

The WoW framework is being effectively shared both within and across organisations, systems and communities. For every individual who completes a WoW workshop or activity many more are exposed to WoW thinking and practice.

Improved health and wellbeing were reported following exposure to the WoW framework. Improved relationships, reduced stress and anxiety, increased physical activity and healthy eating were commonly reported.

Capacity to embed the WoW was supported by its simple and flexible design, and its capacity to be adapted to specific contexts. The perceived personal value of the WoW to participants and its strengths-based approach were also important to embedding and sharing the framework.

Unintended positive consequences identified through the project included strengthening organisational relationships, more collaborative working in local communities, and use of WoW resources to support people during the COVID-19 pandemic.

The WoW has been widely shared by individuals who participated in workshops. This has occurred through both strategic and intentional transmission of WoW thinking and practice and via more organic and informal sharing with colleagues, family and friends.

EXECUTIVE SUMMARY

The Queensland Government has a vision to improve the wellbeing of all Queenslanders. This is outlined in the blueprint *Shifting minds: Queensland Mental Health and Alcohol and Other Drug Strategic Plan 2018 to 2023.* This vision includes whole of person, whole of community and whole of government approaches to improving mental health and wellbeing.

Wellbeing Capacity Building Project

As part of this strategic plan the Queensland Mental Health Commission (QMHC) has continued work to improve positive mental health and wellbeing through the Wellbeing Capacity Building (WCB) Project. Since 2016 the WCB Project has used an evidenced based tool and framework known as the Wheel of Wellbeing (WoW) to build individual, organisational and community wide capacity related to positive mental health and wellbeing. The WCB Project has worked with a wide range of population groups across diverse sectors and settings.

The WoW is a simple framework that includes six elements (*Body – be active, Mind – keep learning, Spirit – give, People – connect, Place – take notice,* and *Planet – care).* The WoW is delivered in workshops and activities designed to engage, inform and encourage people to make changes in their lives which promote mental health and wellbeing, and then to actively share these experiences with others.

Wellbeing Capacity Building Project Review

Lirata Consulting (lirata.com) was commissioned to independently review the WCB Project. This Final Report presents phase one (breadth analysis) and phase two (depth analysis) findings from the WCB Project Review. Case studies providing a detailed analysis of three specific settings are included as appendices.

The WCB Project Review considered four main areas:

- How has the WoW increased awareness and engagement, and facilitated practice change?
- How well have WoW concepts, resources and activities been embedded and integrated?
- Which capacity building model elements have enabled and supported desired outcomes?
- What transmission and ripple effects have occurred and what pathways have supported these?

Our analysis included 118 respondents across key stakeholder interviews and focus groups, a practitioner survey (responded to by 20% of all WoW Practitioners), and a postcard allowing end users touched by the WCB Project to participate. The majority of review participants came from the education sector, however there was also strong representation from the community services and health sectors. Government, business and community representatives were also included.

Findings

Awareness, engagement and practice change

Review participants identified increases in awareness and engagement, and practice change related to positive mental health and wellbeing through exposure to, and uptake of WoW concepts, information and activities including through WoW workshops and activities. Our findings suggest that changes in awareness about positive mental health facilitated changes in engagement, which in turn encouraged behaviour and practice change.

Changes in awareness and engagement were more evident than changes in practice, although there were noticeable increases across both dimensions. Changes were evident at individual, organisational, and broader systems and community levels.

Commonly reported changes in awareness and engagement included understanding the science behind positive mental health and wellbeing, and the existing assets and resources people already had available to meet their health goals and needs. Practice changes included changes to individual behaviours, and organisational and broader systems changes. Behaviour and practice change, both individual and organisational, was especially evident across the dimensions of social relationships, and physical and psychological health.

Awareness, engagement and practice changes were identified in all sectors and settings with the education sector providing the most numerous and diverse examples. Community and health services, as well as the government sector, also provided robust demonstrations of increased awareness, engagement and practice change resulting from implementation of the WoW.

There is qualitative evidence to suggest there have been improvements in mental health and wellbeing resulting from project participation.

Embedding and integrating the WoW

WoW practitioners responding to this review reported conducting more than 500 workshops and activities which were most commonly offered in the education, community and health sectors. Diverse use of WoW concepts, activities and resources was shared, and flexible adaptation of these assisted integration and embedding of the framework in different settings.

Participants believed the WoW had been successfully integrated and embedded in many organisations, evidenced through cultural, process and practice changes in these settings, including using the WoW to frame service delivery, and to develop principles, policies and training programs.

Systems level changes were also noticeable, including the development of bespoke WoW content for specific settings and populations, and use of the WoW to help prioritise, plan and coordinate collaborative activities with diverse stakeholders in the community.

Aspects of the WoW considered important to integration and embedding included: the WoW tool itself, including the six WoW elements; the resources provided to both participants and facilitators; the WoW online program; and the WoW Theory of Change.

Additional factors important to effective WoW implementation and embedding included Wow champions, local leadership, WoW facilitator numbers and capacities, and the simple and flexible nature of the WoW framework. Barriers to further integration included resource constraints, loss of advanced practitioners, the

COVID-19 pandemic, and significant travel distances in regional areas. Sustainable funding models will require consideration for further implementation and integration of the WoW.

Capacity building model

QMHC structured the WCB Project in key phases designed to build individual, organisational and systems and sector capacity. The first project phase focused on building awareness and engagement around positive mental health and wellbeing, and the WoW framework. Subsequently, additional phases focused on the strategic engagement of community and education sectors. A WoW Support Program was developed to identify, resource and implement actions designed to foster strategic engagement of these sectors and improve project sustainability.

The capacity building model set out in the WoW Theory of Change (ToC) was well supported. Activities considered important in initiating change included the workshops and resources provided, and the ability to adapt these resources to local context and population groups. Demonstrating the evidence supporting WoW practices, providing opportunities to learn through practical activity, and building strong social connections were recognised as important mechanisms supporting change.

It was acknowledged the capacity building model was resource intensive, but that substantial benefits were accrued through sharing of wellbeing knowledge, practice and resources to others following participation in workshops and activities.

Additional existing capacity building elements were identified which could be included in the ToC. These included concepts related to ‘doing it for yourself first’, the diversity of channels with which WoW could be offered and its strengths-based approach.

Some participants suggested future focus on capacity building could also consider further strategic engagement of key sectors, broadening support for local WoW facilitators and champions, and moving more activity online.

Transmission and ripple effects

Most participants were introduced to the WoW in their workplace (including schools), others discovered the WoW through local and sector networks. Nearly all participants in this review shared their new WoW knowledge with others and this should be viewed as a key project strength.

The WoW was shared both within (vertically) and across (horizontally) organisations, systems and settings. Both structured and intentional ‘transmission’, and organic ‘ripple’ effects were identified which helped to disseminate the WoW to diverse settings and population groups.

Individual horizontal transmission effects were identified with transfer of WoW thinking and practice from the workplace into family settings or activities with friends. Important organisational vertical transmission effects included widespread dissemination in workplaces and schools, for example from primary to middle schools, or from teaching staff to students. Inclusion of WoW content at executive meetings and structured training programs also facilitated organisational transmission. At a systems level the WoW was transmitted horizontally through adaptation and use as a planning and service coordination tool, and through sharing WoW activities with other community service providers and community members.

Ripple effects, while more unstructured and organic, were considered just as valuable. At an individual level, students and teachers brought WoW concepts back to their homes, and parents were supported with

resources through the COVID-19 pandemic during 2020. Organisational and systems level ripple effects also occurred through staff role transitions and community based 'word of mouth'.

Pathways considered important to facilitating transmission and ripple effects were advocacy within key systems and networks, including champions in these settings, and the regional wellbeing hubs which promoted uptake of the WoW in local settings. WoW practitioners and grass roots community WoW supporters were also identified as important conduits for sharing WoW thinking, practice and resources.

The way in which the WoW has been effectively shared and disseminated into diverse sectors and settings is a key strength of the model.

Conclusion

The WCB Project has been operating since 2016. During this time the project has successfully engaged a diverse range of stakeholders, sectors and settings. Those participating in WoW workshops have successfully shared information and activities, and built motivation and behaviour change to support improved health and wellbeing.

These changes have occurred within individuals, who have in turn influenced the organisations, systems and broader community settings in which they work and live to integrate and embed the WoW. Transmission of key WoW concepts and practices has been widespread and generated significant momentum for positive mental health and wellbeing activities in education, community health and government sectors, and in community settings.

CONTENTS

1 OVERVIEW OF THE WCB PROJECT

The Queensland Mental Health Commission (QMHC) Mental Health and Wellbeing Capacity Building (WCB) Project is working to improve the capability of individuals, organisations, systems and communities to promote and build positive mental health and wellbeing.

The WCB Project engages stakeholders across education, health and community, government and business sectors, and works systemically in local communities to improve positive mental health awareness, knowledge and skills. The project is being run in partnership with Implemental (implemental.org) who are the program content providers.

The WCB Project is using the Wheel of Wellbeing (WoW) to build mental health and wellbeing capacity. The WoW is an evidence-based approach to improving health and wellbeing. The simple framework now includes six elements proposed to contribute to health and wellbeing: *Body – be active, Mind – keep learning, Spirit – give, People – connect, Place – take notice,* and *Planet – care.*

FIGURE 1: THE WHEEL OF WELLBEING

WoW framework and resources

The WoW framework and the resources supporting it have evolved since their development in the United Kingdom in 2009.

In Queensland today WoW activities and resources include:

- A one-day introductory workshop
- A five-day intensive workshop (DIY Happiness)
- Flexible WoW activities across schools, workplaces, networks, service systems and communities
- An online self-directed WoW course
- Support and mentoring
- An online WoW practitioner support and resource platform (Moodle).

2 WCB PROJECT REVIEW

The WCB Project Review was undertaken by Lirata Consulting (lirata.com) and included a two-stage review process.

Firstly, a breadth analysis was completed to understand broad structural project elements, implementation processes, settings in which activities are occurring, and the capacity building model being used.

Subsequently a depth analysis was conducted in six WCB Project settings to understand important contextual factors across distinct sectors and settings, local enablers and barriers, and how the WoW framework and activities had been disseminated within organisations, systems and communities.

2.1 Methods and participants

Breadth analysis

The breadth analysis included key stakeholder interviews, a WoW practitioner survey and a WoW postcard.

Key stakeholder interviews were conducted with the project content developer (n=1), and regional project managers and WoW champions (n=3). Information gathered through ongoing meetings with the QMHC WCB Project lead was also included.

A **WoW practitioner survey** was conducted with people who had completed a five-day intensive WoW Program and were training others in mental health and wellbeing capacity building activities using the WoW. The survey was sent to 233 people via the online platform Moodle. Forty-eight people returned the survey, including nine of 11 advanced practitioners (81%), 37 of 222 WoW practitioners (16%) and two other individuals who were in the process of being verified as a WoW practitioner. This means advanced practitioner data is likely to be more representative than the data for the other practitioners.

Most survey respondents had been involved in the WCB Project for more than two years (59%), while 35% had been involved for between one and two years. Only 6% of participants had less than one year's involvement.

A short four question **WoW postcard** was provided to gather data from individuals who had participated in either a WoW workshop or activity (n=49). Demographic data was not collected.

Depth analysis

Following completion of the breadth analysis, consideration was given to the most appropriate settings in which to undertake a more detailed analysis of factors influencing WoW implementation, integration, and transmission. Five criteria were considered in identifying appropriate settings and sites:

1. Motivation – sites were motivated to participate
2. Capacity – sites had capacity to participate, and could do so in November-December 2020
3. Diversity – sites included all WCB Project sectors funded (Education, Community and health, Government)
4. Approvals – sites did not require Human Research Ethics Committee (HREC) approval to gather data
5. Strategic alignment – sites chosen were aligned with QMHC priorities and areas of interest.

Six 'depth analysis' settings were subsequently chosen, these were:

- Two regional wellbeing hubs and communities
- One community service organisation
- One government organisation
- Two schools.

A total of 18 individual participants were consulted, including six in community settings, five in education settings and seven in government settings.

Three case studies showcasing local conditions and factors relevant to WoW success implementation, adoption, and broader transmission of the WoW were also developed. One case study was developed for each key WCB Project setting: Education, Community, and Government. These are available at *Appendix 1 - WoW Case Studies.*

2.2 Review questions

Findings in relation to the six WCB Project review questions have been consolidated into four chapters.

Chapter 3: Awareness, engagement and practice change

- Question 1 – How has the WCB Project fostered increased awareness, engagement and practice change in positive mental health and wellbeing?

Chapter 4: Embedding and integration of concepts, activities and resources

- Question 2 – How well have the concepts, resources and activities related to the WoW been embedded and integrated into organisational processes and practice models?
- Question 3 – What evidence exists of those settings or sectors that have particularly adopted and embedded the concepts, resources and activities of wellbeing and WoW?
- Question 5 – Which elements of the wellbeing and WoW concepts, resources and activities have been most beneficial and to which sectors and practitioners?

Chapter 5: Model elements enabling desired outcomes

- Question 4 – Which elements of the capacity building model have enabled and supported desired outcomes?

Chapter 6: Transmission and ripple effects

- Question 6 – What ripple effects have occurred and what has supported these?

2.3 Definitions

Definitions for key terms used in this report are set out below.

WoW Practitioners

WoW practitioners deliver workshops and activities using WoW branded resources and tools. All practitioners have access to the support and resource platform, Moodle. There are two levels of WoW practitioner. These practitioners have gained a strong understanding of the WoW framework and can effectively integrate it into their work and practice.

WoW practitioners

WoW practitioners have completed the one-day introductory workshop, and the five-day intensive workshop. The five-day intensive includes completion of all content in the first four days, followed by facilitation of a one-day workshop to gain accreditation.

Advanced WoW practitioners

Advanced WoW practitioners have completed the one-day introductory workshop, five-day intensive workshop and an additional three days of training. Following this, advanced WoW practitioners must run a five-day intensive workshop themselves to gain accreditation. Advanced practitioners may adapt the five-day intensive workshop for particular settings and population groups and do so regularly. For example, a WoW Ed Intensive Workshop has been developed for education settings, and for an alcohol and other drug rehabilitation service. There are currently 11 WoW advanced practitioners operating across Queensland.

Level of change

There are three levels of change consistently identified through this report: individual; organisational; and network, system and community level changes.

Individual changes

When we discuss individual changes, we mean those changes which are being made by individuals who have participated in workshops or activities, irrespective of where they are making them. For example, individual changes may occur by practicing more mindfulness activities in a workplace setting or at home. Activities that are directed by one person, but include others, for example setting up a 'weekly wellbeing walk' with a friend, or encouraging a family gratitude discussion at dinner time, would also be considered individual changes as they are being instigated by one person.

Organisational changes

When we discuss organisational changes, we mean changes that are occurring in a workplace (including school) setting and include the participation of a group of people. These are activities like incorporating WoW concepts and activities into staff meetings or school curriculum, or running group meditation classes.

Network, system and community changes

When we discuss network, system, or community changes we mean changes in settings which include more than one organisation or in the broader community. This may be through a network (e.g. youth worker network), system (e.g. the Department of Education), or community (e.g. a specific geographic area associated with, for instance, sporting clubs or volunteering organisations).

Ripple and transmission effects

As data analysis occurred it became clear that two distinct types of WoW concept and activity dispersion were occurring. One type (transmission effects) was occurring through structured and planned activities, the other (ripple effects) was occurring in a more organic way.

Transmission effects

Activities which are structured and intended to transmit WoW thinking and practice within and across different settings. For example, a local council representative attends WoW training and then organises follow up WoW activities with the Country Women's Association and Men's Shed as part of their annual workplan, transmitting key WoW practice into the community.

Ripple effects

Activities which lead to informal or unstructured sharing of WoW thinking and practice both within and across settings. For example, a teacher attends WoW training with the intention to use ideas and activities in their classroom, but then also uses these activities at home and with their local netball team.

Vertical and horizontal effects

This report uses the categorisations of vertical and horizontal transmission and ripple effects to distinguish between sharing of WoW thinking and practice within an organisation, setting or system (vertically) and between organisations, settings and systems (horizontally).

Vertical effects

Relate to the sharing of WoW practice within an organisation, setting or system. For example, schools produced vertical effects by sharing WoW practice from their primary school into their middle school. Education systems shared vertical effects by transmitting learnings between local schools.

Horizontal effects

Relate to the sharing of WoW practice outside of the original setting it was learned or intended for. For example, many WoW participants attended training in order to build health and wellbeing capacity in their workplace but have also used what they learnt with family and friends.

3 FINDINGS: AWARENESS, ENGAGEMENT AND PRACTICE CHANGE

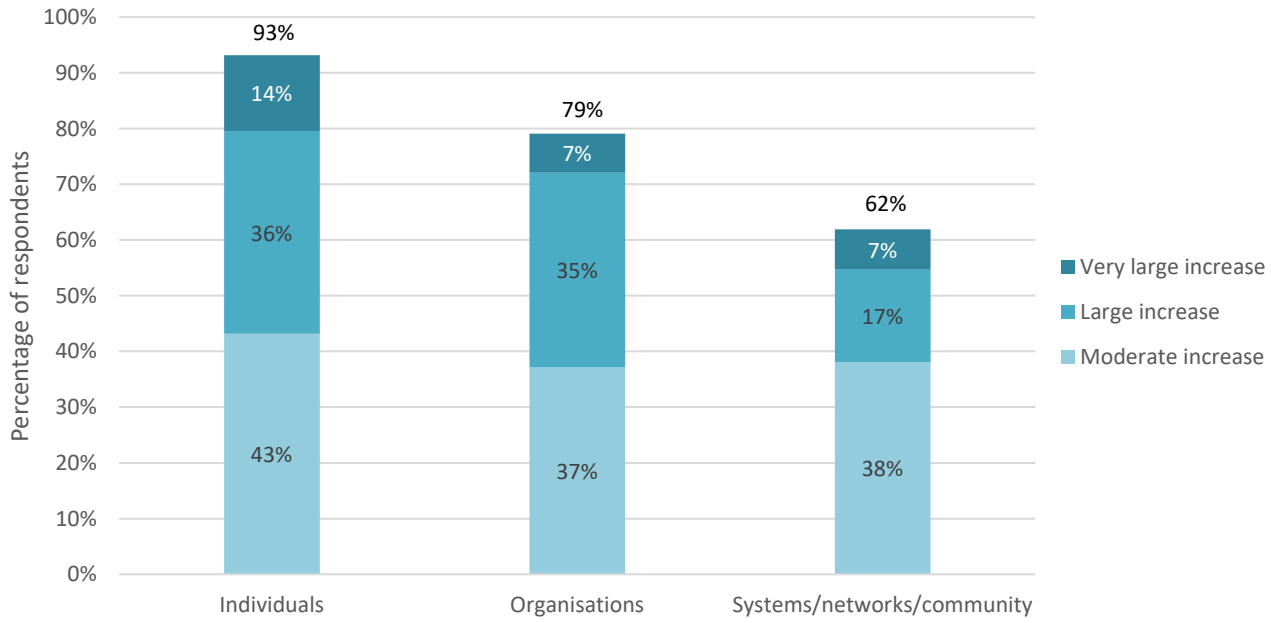
3.1 Changes in awareness and engagement

The WCB Project Review found strong evidence for increased awareness and engagement related to positive mental health and wellbeing through implementation of the WoW. This included increased awareness and engagement at three levels: individual; organisational; and network, system, and community.

Importantly, individual changes appeared to be influencing broader change. There were many examples where individuals promoted and championed organisational and broader systemic awareness-raising in their setting.

Figure 2 (below) shows the percentage of practitioner survey respondents who believed there had been a '*moderate increase'*, *'large increase'* or *'very large increase'* in awareness and engagement in positive mental health and wellbeing through the WCB Project. Other responses available to participants were *'small increase'* or '*no increase*'.

FIGURE 2: CHANGES IN AWARENESS AND ENGAGEMENT



Noticeable **individual changes** in engagement and awareness were reported by approximately 95% (41/44) of practitioner survey respondents. These respondents believed there had been a *'moderate'*, *'large'* or *'very large'* increase in positive mental health awareness and engagement as a result of participation in the WCB Project. 'Individual' increases in engagement and awareness refers to the individuals who participated in some type of WoW workshop or activity, including activities run in local organisations or settings.

Organisational changes were also commonly reported. Approximately 80% (34/43) of survey respondents reported *'moderate', 'large'* or *'very large'* increases in awareness and engagement related to positive mental health in their organisations. This means respondents believed that awareness and engagement increases occurred with other organisational staff after WoW workshop and activity participants brought

their WoW thinking and practice back to the workplace. For example, many respondents noted increased conversations about wellbeing in the staff room and in staff meetings.

Network, system and community level changes showing *'moderate', 'large'* or *'very large'* increases in awareness and engagement were reported by approximately 60% (26/42) of practitioner survey respondents. This occurred in settings such as network meetings, community forums and sector level events.

These quantitative findings suggest that exposure to WCB project workshops and resources have allowed individuals, organisations, and broader networks, systems, and communities to increase their awareness of, and engagement in, positive mental health and wellbeing. A discussion of key themes and examples from the qualitative data is outlined below.

Breadth and depth stakeholder interviews and focus groups, qualitative practitioner survey responses and postcard feedback supported important positive changes in awareness and engagement related to health and wellbeing.

> Between schools and across educational systems there has been a growing recognition of the science behind WoW (key stakeholder interview)

Awareness was improved through sharing knowledge of the evidence and science behind positive mental health and wellbeing, especially in organisational settings. Furthermore, individuals appeared to improve their understanding about the range of assets and activities available to them in their lives which supported wellbeing. Others reported improved awareness that the WoW was consistent with their own beliefs and values about wellbeing, which made concepts easier to adopt.

> I think that WoW has created a language... for people to talk about wellbeing in the workplace (practitioner survey)

Awareness increases also related changes in the language used to describe mental health and wellbeing, with participants noting important shifts toward more health promoting language. At a personal level many respondents also felt they were more aware of their own emotions after completing WoW workshops and activities.

Engagement with health and wellbeing thinking and practices appeared to be a natural flow-on effect of increased understanding and awareness, leading to strong demand for activities in many settings. Participants highlighted strong engagement around WoW thinking and practice in all settings in which the WoW was introduced, with engagement often initially led by individuals who were then able to motivate and engage the broader organisation or system they worked in. Organisational leaders who participated in WoW workshops and activities were noted to be prioritising wellbeing conversations and activities, as were staff who felt encouraged and empowered to talk about their health and feelings. The WoW appeared to stimulate and authorise greater permission to talk about positive mental health and wellbeing, which in turn facilitated engagement of others.

Practical examples of increased engagement and awareness included:

- High demand from local community organisations (e.g. primary health network, Lions Club and pre-schools) for facilitators to attend meetings and share the WoW, after discussions at local network meetings (*Network, system and community level)*

- Staff survey responses discussing satisfaction with WoW resources and activities, and how the organisation cares about staff wellbeing; a noted change from previous years (*Organisational level)*
- Changes in the way organisations were discussing mental health, reorientating deficit thinking and language to more positive mental health frameworks (*Organisational level)*
- Dinner time conversations with children and partners, especially in relation to social and environmental activities, and subsequent attendance at community events (*Individual level)*
- Validation and reinforcement of own personal beliefs and values, which in turn increased interest and commitment in undertaking positive mental health and wellbeing activities (*Individual level).*

Spotlight example

A regional mental health and wellbeing hub facilitator ran a workshop with vulnerable people who described experiences of disempowerment and disconnection, including service system responses which made them feel labelled and judged.

The facilitator observed high levels of engagement with the WoW through the day and believed participants were energised by the opportunities they saw in the WoW framework and activities which participants stated were non-judgemental, simple, and positive.

In feedback forms, participants described feelings of empowerment, new awareness about their mental health assets and resources, and a more strengths-based framework with which to think about their wellbeing. They believed they would use the WoW tool and activities in the future.

Together, the quantitative and qualitative findings suggest strong improvements in awareness and engagement related to positive mental health and wellbeing as a result of participation in the WCB Project. Importantly changes in individual awareness and engagement (through workshop participation) have led to awareness and engagement about positive mental health in broader organisational settings, and to other network, system and community settings.

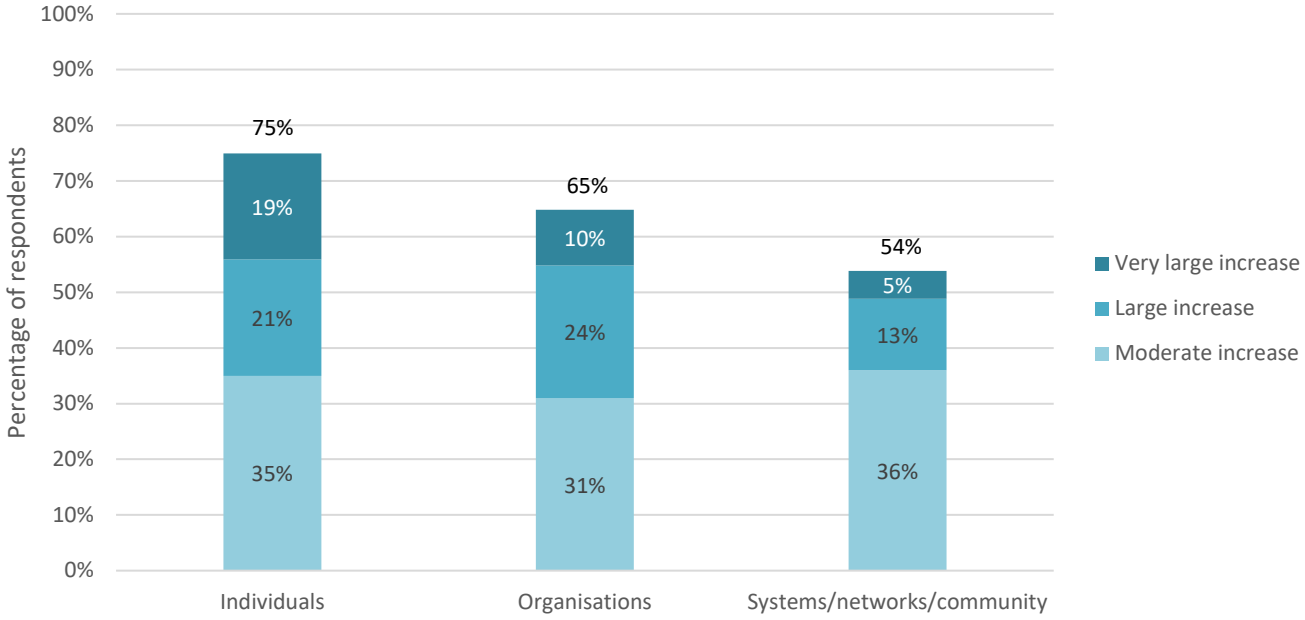
3.2 Changes in practice

While increases in awareness and engagement related to positive mental health and wellbeing confer important benefits, it is hoped these changes result in sustainable improvements which embed and integrate new behaviour and practices which support wellbeing.

Amount of practice change

Figure 3 (below) shows the percentage of practitioner survey respondents who believed there had been a '*moderate'*, *'large'* or *'very large'* increase in practice change related to positive mental health and wellbeing through participation in the WCB Project. Other responses available to participants were *'no'* or '*small'* increase(s).

FIGURE 3: PRACTICE CHANGES IN POSTIVE MENTAL HEALTH AND WELLBEING



Individual practice changes showing *'moderate', 'large'* or *'very large'* increases were reported by approximately 75% (32/43) of respondents, however almost half of these participants (35% of all respondents) believed changes had been only 'moderate'.

Organisational practice changes showing *'moderate'*, *'large'* or *'very large'* increases were reported by 65% (27/42), however around half of this group (31% of all respondents) rated the practices changes as only moderate.

Similarly, **network, system, and community level practice changes** were identified as *'moderate', 'large'*, or *'very large'* by 54% (21/39) of respondents. The majority of this group (36%) rated the changes as only moderate.

This quantitative data from the WoW Practitioner Survey suggests that noticeable changes to practice were apparent through participation in the WCB Project. While perceived practice changes were more commonly *'moderate'* than *'large'* or *'very large'*, consistent practice change was reported across individual, organisational, and at broader systems and community levels. Outlined below is a detailed discussion of these practice changes by each of these levels and the sector or setting being targeted.

Types of practice change

Qualitative analysis supported quantitative findings showing positive mental health and wellbeing practice change at individual, organisational, and network, system, and community levels. Individual changes were most commonly reported, and this is unsurprising as individual practice change is a necessary condition for broader organisational and systems level changes, and also because the WoW delivery methods start with individuals, who then diffuse learnings into their organisations and networks.

Individual practice change

A number of common behaviour and practice change themes were identified at an individual level. Many of these themes coalesced around specific WoW elements.

The capacity to **reflect on current mental health and wellbeing** was commonly reported. People were using the WoW to audit what they were doing across each of the six WoW elements. For example, using the WoW elements to review personal activities, creating a WoW calendar, and using the *Keep, Stop, Start (doing) Activity*.

> We started no screens at dinner time (key informant interviews)

Changed behaviour related to **social engagement and support for others (*People – connect*)** was regularly reported, with participants highlighting connection with others through planned family time, walking with friends, gardening and sporting activities. Increased capacity to share feelings with others was also reported, especially as this related to workplace colleagues and settings.

Participants reported increased **psychological care and development (*Mind – keep learning*** and ***Spirit – give*)** by completing mindfulness activities, taking up new courses, participating in yoga, pilates and tai chi, and engaging in gratitude reflections and 'random acts of kindness'. An increased confidence and capacity to say 'no' when overburdened was another commonly shared example of improved psychological care. Developing a better understanding of 'flow states' *(a feeling where you become fully immersed in whatever you are doing)* and the advantages of creating a psychological mindset which facilitates this was also a common psychological development activity.

Increased physical health behaviours (*Body – be active*) were commonly reported. Participants joined sporting clubs, started hobbies, took up walking and running and participated in yoga, pilates and tai chi. A stronger focus on healthy eating was also reported.

Being more environmentally friendly and engaging with the environment was another strong theme. Participants discussed volunteering in tree planting days, doing more gardening and composting, and spending more time talking to their children and grandchildren about environmental issues.

Specific examples of individual practice changes included:

- Students were encouraged to create their own projects at home during COVID-19 as a way to help them find their 'flow state'. They were asked to reflect on what happened when mindfully immersed in a task they really enjoyed.
- An isolated elderly couple attending a WoW workshop found new community connections and subsequently joined into multiple community activities.
- Students created their own personalised mindfulness scripts (in some cases these were taken home and shared with their family).
- Starting a 'social isolation project' that included board games with a focus on *Mind – keep learning* and *People – connect* by strategically using mindfulness games and social interaction activities.

Spotlight example

One participant discussed reviewing what activities they could do as a family that would build positive mental health and wellbeing. This family identified low or no cost community activities under each WoW element, they would then decide on one or more activities each weekend. They believed the WoW framework assisted family decision making and they often decided on specific activities linked with an individual WoW element based on how they were feeling. Over six months they collated a notebook of activities.

Respondents believed significant individual behaviour and practice changes related to positive mental health and wellbeing occurred through WCB Project participation. Strong themes related to changed social engagement, and physical and psychological health practices were evident. Notably, 15 practitioner survey and postcard responses mentioned the value of WoW thinking and practice in supporting them and others during the COVID-19 pandemic in 2020.

Organisational culture, process and practice change

Significant organisational changes were also identified during the review. These have been categorised as cultural changes, process changes, and practice changes. It is acknowledged there is some overlap in these categorisations.

Common **organisational culture change** examples included embedding aspects of the WoW into broader organisational thinking and practice, including organisational documents. This included:

- Re-framed organisational conceptual models of health and wellbeing which were more strengths-focused and encouraged more positive language
- Consolidating organisational health and wellbeing practice under the WoW framework; using the WoW as the organisational 'service model'
- Integrating the WoW framework into school policies, for example a school code of conduct and student wellbeing policy
- Embedding the WoW framework into an organisational induction and staff training program.

> I lead over 200 staff… we implemented WoW strategies across our workforce including workshops for staff, workshops incorporated into our induction program, a WoW group who co-ordinate activities and people undertaking the WoW lite program (postcard)

Organisational process changes related to the WoW were identified. Participants reported integration of the WoW into workplace processes and communications; common examples included:

- Using the WoW as an auditing and planning tool
- Creating wellbeing as a standing agenda item at staff meetings, with a different WoW element considered at each meeting
- Weekly emails sharing 'WoW updates' with tips and tricks to encourage participation in wellbeing activities
- Promotion of local community wellbeing activities via social media channels.

> We have it (wellbeing) on the agenda at each staff meeting now, we use the WoW to check in (practitioner survey)

Organisational practice changes were also evident. Many workplaces adopted WoW ideas to support staff (including teachers') self-care, to develop relevant organisational and educational content, to create more thoughtful approaches to difficult behaviour, and to structure organisational activities. Examples included:

- Integrating activities into the school curriculum, including activities under each WoW element
- Changed behaviour management strategies with students, and a greater focus on 'relationship building'
- Using the WoW to structure mental health week activities, and staff and student wellbeing days
- Development of a 'WoW community group' (developed on Facebook) that promoted and ran community wellbeing activities outside of the organisation following exposure to wellbeing thinking and practice within the organisation
- Ringing a bell at 11am and 3pm to remind people to get up, stretch and take a break
- Classes sending home 'care packages' for children who are sick
- Embedding weekly staff group exercise activities at a school
- Embedding mindfulness sessions before school staff meetings
- Creating a buddy system through a program titled 'Dwarves and Giants'.

> We ran a week of wellbeing during mental health week incorporating a piece of the wheel each day (postcard)

> We now do something for each day of the week: mindful Monday; take notice Tuesday; well-being Wednesday; thoughtful Thursday; fun Friday (depth interview)

Significant organisational culture, process and practice changes were reported during the WCB Project Review. It appears that individuals receiving WoW training are bringing ideas back to their workplaces and encouraging adoption of new thinking and practice. These cultural, process and practice changes appear to be assisting organisations to embed the WoW framework. While these changes take time, there is clear evidence the WoW is taking hold in many organisational settings.

Systems practice change

Important **network, systems and community level practice changes** were identified through the WCB Project Review. Participants considered these changes valuable as they helped to share WoW messages about positive mental health and wellbeing with broader groups. Key changes included:

- Formative development of a new not-for-profit organisation who would provide fee for service WoW training (currently in recess due to funding and COVID-19 barriers)

> The community Wheel of Wellbeing inspired the establishment of the Central Queensland Wellbeing Hubs Inc. a not-for-profit organisation developed from seven individuals who attended a WoW workshop and wanted to continue building positive mental health capacity in the region (practitioner survey)

- Refinement and adaptation of the WoW specifically for use in education settings (*Wow Ed*) by Implemental and education system staff
- Refinement and adaptation of the WoW for other settings, including alcohol and other drug and disability settings
- A large community service organisation embedding aspects of the WoW into all state and national team meetings
- A WoW participant who had completed training for their school subsequently shared WoW thinking and activities with 50 local area principals
- Development of an online WoW program
- Discussions about the WoW, and positive mental health and wellbeing in network meetings (e.g. mental health coach networks, youth networks, school health nurse networks, mental health networks)
- Sharing WoW concepts and activities in community forums and sporting clubs through presentations.

> It ended up there were these really positive powerful passionate women [from the 1-day WoW workshop] who grabbed the WoW and went 'this is great', and then spread it around the 13 communities, delivering training and workshops (depth interview)

Regional wellbeing hubs

Embedding the WoW into regional wellbeing hubs (https://www.qmhc.qld.gov.au/awareness-promotion/mental-health-wellbeing/regional-wellbeing-hubs) and using the WoW framework to support broader community service coordination and engagement was a key practice change identified in local communities. WoW champions in hubs have facilitated its use across a broad range of community settings by encouraging its use for collaborative planning and service delivery activities.

Examples of important systems and community changes reported through hubs included:

- Using the WoW in development of a local area co-designed 'collaborative action plan'; this included more than 40 community and health services, 80 community members, local councils, and state and federal government departments
- Using the WoW as an overarching framework for service provision across a local area, while still allowing organisations to retain their own identity and service models
- Using the WoW to develop service agreements about improved coordination and outreach provision to an isolated island
- Using the WoW as a decision-making tool for project activities with multiple service providers
- Training trusted local people (rather than outsiders) to run WoW activities in vulnerable communities.

Spotlight example

WoW activities led by a regional wellbeing hub prompted a review of activities at a Men's Shed. This included using the WoW framework to inform new governance structures and process.

The WoW was also used to more clearly define the Men's Shed practice model using the six WoW elements to clarify the services they offered. Changes resulted in increased numbers of men accessing the service, and the provision of outreach health services at the Men's Shed. This was viewed as especially important because many of the men in the area were recognised as isolated and vulnerable.

It is particularly important that significant systems and community level practice changes were identified during the WCB Project Review. This suggests the WoW framework is being effectively shared both within and across organisations, systems and communities, in some cases disseminating new health and wellbeing thinking and practice to isolated and vulnerable communities. Systems and community level practice changes have also brought people and organisations together to plan and coordinate their work more effectively and to use the WoW as an agreed service framework. The education sector and other settings have adapted the WoW so practices can more easily be implemented in these settings.

3.3 Changes by sector

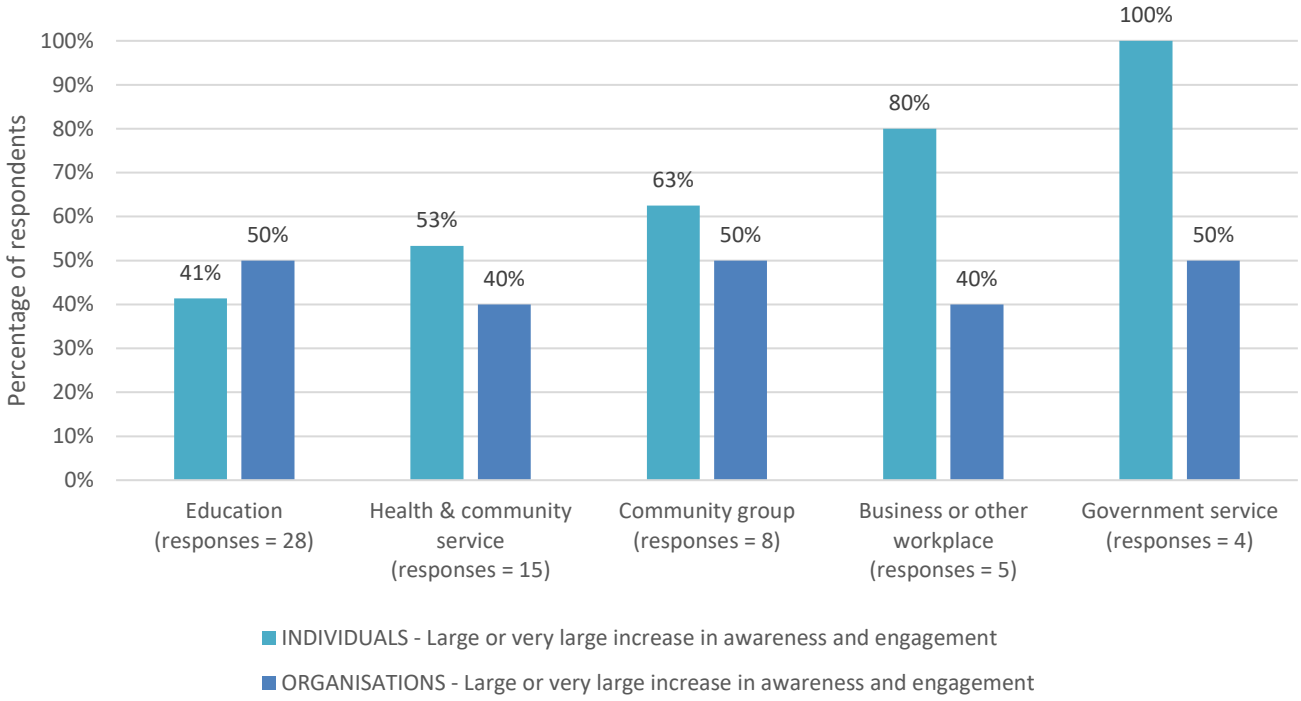
Awareness and engagement changes

Separate to their broad perceptions about changes in awareness and engagement, WoW practitioners were asked to consider changes by specific sector or setting. Results are shown in There were 60 responses from the 48 people who answered questions about the sector(s) they worked in, with some respondents providing responses for more than one sector.

Figure 4 (n=48).

Only responses for *'large'* and *'very large'* increases are shown. Other options available were *'moderate', 'small' or 'no'* increases. Survey participants were asked about changes for individuals and organisations (but not systems and communities). There were 60 responses from the 48 people who answered questions about the sector(s) they worked in, with some respondents providing responses for more than one sector.

FIGURE 4: CHANGES IN AWARENESS AND ENGAGEMENT BY SECTOR



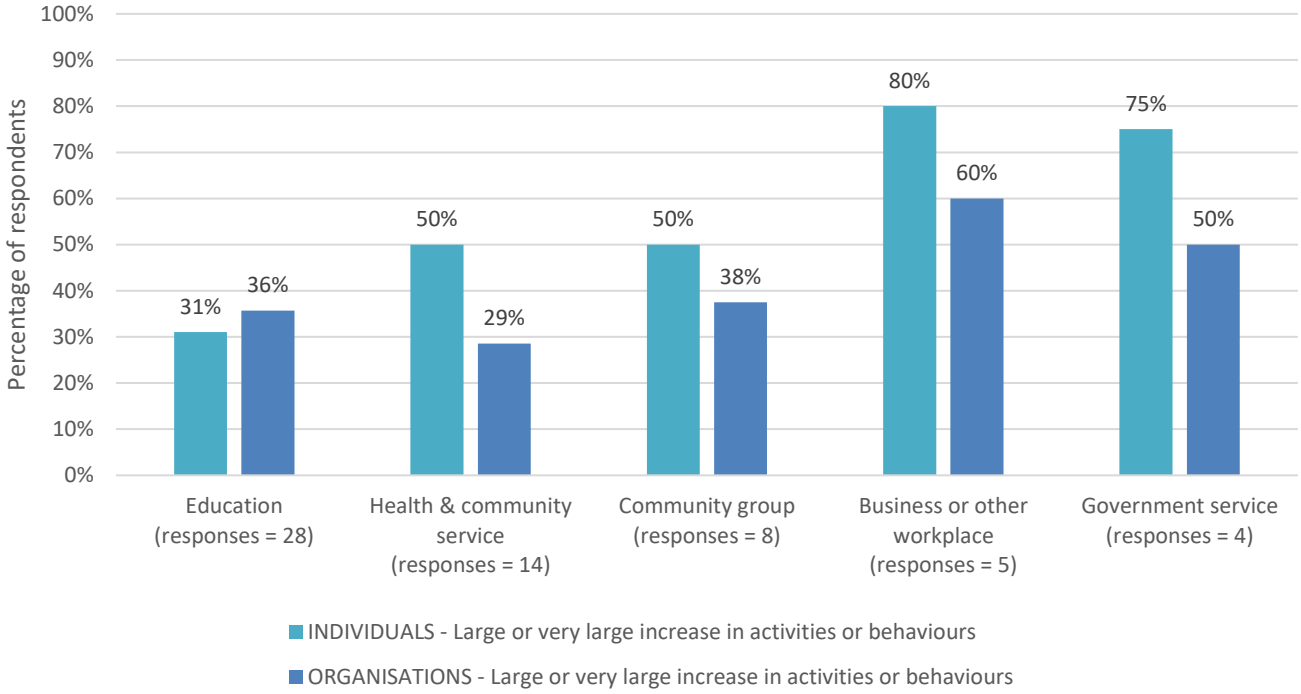
The small number of respondents in some sectors means this data should be viewed with caution, however two points of interest are noted. Firstly, we generally see larger changes in awareness and engagement for individuals compared to organisations, and secondly, substantial changes in awareness and engagement are noted across all sectors for both individuals and organisations.

It should be noted that the majority of responses were from the education sector. More responses from this sector may indicate stronger engagement with the WoW. It is notable that respondents from the education sector reported more 'organisational change' than 'individual change', a surprising result given that respondents regularly discussed the value of individual changes in awareness and engagement driving broader organisational and systems change in their settings. It may be that practice change in the education sector has been particularly strongly supported by schools adopting the WoW.

Practice changes

Figure 5 shows practitioner survey results for perceived changes in practice by sector (n=48). Only responses for *'large'* and *'very large'* increases are shown. Other options available were *'moderate', 'small' or 'no'* increases. Survey respondents were asked about changes for individuals and organisations. Some participants provided responses for more than one sector, thus providing 59 responses in total.

FIGURE 5: CHANGES IN PRACTICE BY SECTOR



The small number of respondents in some sectors means this data should be viewed with caution. Consistent with awareness and engagement changes above, practice change is more noticeable for individuals, compared to organisations, and respondents believed practice change had occurred for both individuals and organisations in all sectors.

It should be noted the majority of responses were from the education sector. More responses from this sector may indicate stronger engagement with the WoW. It is again notable that respondents from the education sector reported more 'organisational change' than 'individual change'.

Changes by sector

Outlined in Table 1 (below) comparing perceived awareness and engagement, and practice change across the education sector, community and health sector, government sector and in community groups.

'Businesses and other workplaces' have not been included in the comparison due to the low sample size in the practitioner survey and the fact this sector was not targeted in the depth data collection phase. This means it would be unreasonable to make review comments based on such a small sample in isolation.

TABLE 1: CHANGES BY SECTOR

Changes observed	Education	Health & community services	Government services	Communities & community groups
Awareness & Engagement – Organisational level				
• Improved understanding about the evidence and science behind positive mental health and wellbeing	✓	✓	✓	

Changes observed	Education	Health & community services	Government services	Communities & community groups
• Leaders prioritising wellbeing conversations and activities	✓	✓	✓	
• Improved understanding of the assets and activities which support wellbeing	✓	✓	✓	✓
• Changes in the way health is described – shifts to more wellness focused language	✓	✓	✓	✓
• Increased awareness about strategies to maintain wellbeing	✓	✓	✓	✓
• Requests for more wellbeing activities	✓	✓	✓	✓
• Communications promoting WoW activities	✓	✓	✓	✓
Awareness & Engagement – Network & System level				
• WoW advocacy and promotion by the Principal Advisor – Mental Health Student Engagement and Wellbeing – North Coast region (Department of Education)	✓			
• WoW advocacy and promotion by regional wellbeing hub representatives		✓		
• Improved understanding about the evidence and science behind positive mental health and wellbeing	✓	✓		
• Leaders prioritising wellbeing conversations and activities	✓	✓	✓	
• Leaders advocating for systemic WoW implementation	✓	✓	✓	
• Increased awareness about strategies to maintain wellbeing	✓	✓		✓
• Discussions with executive management to systematically expand WoW adoption to other services in the region		✓	✓	
• Discussions about further use and adoption of the WoW with community and health service providers at a regional wellbeing hub		✓	✓	
• Requests for more wellbeing activities	✓	✓		✓
Practice – Organisational level				
• Integrating the WoW framework into school policies	✓			
• Using WoW tools to audit wellbeing	✓		✓	

Changes observed	Education	Health & community services	Government services	Communities & community groups
• Including WoW as a standing agenda item at staff meetings	✓	✓		
• Using WoW to frame student and staff wellbeing days	✓			
• Changed behaviour management strategies	✓			
• Using WoW in the school curriculum	✓			
• Increased activities designed to promote social connectedness	✓	✓	✓	✓
• Increased workplace psychological care activities	✓	✓	✓	
• Increased workplace physical care activities	✓	✓	✓	
• Using the WoW as an organisational service model or framework		✓		✓
• Using the WoW in induction and staff support and development training			✓	
• Running multi-day WoW workshops			✓	
• Development of a WoW community support group (outside the workplace)			✓	
• Using WoW to develop governance and practice models		✓		✓
Practice – Network & System level				
• WoW framework adaptation for use in education settings (*Wow Ed*)	✓			
• Discussion of WoW in network meetings	✓	✓	✓	
• Systematic sharing of the WoW with other schools	✓			
• Using the WoW to frame service models and delivery		✓		✓
• Using WoW as an overarching framework for service coordination		✓		✓
• Using WoW to help in service co-design		✓		✓
• Changed service provision practices		✓		✓
• Discussion of WoW in network meetings (youth, education, mental health, and alcohol and other drug)	✓	✓	✓	
• Using WoW as decision making tool for activities	✓	✓		✓

Changes observed	Education	Health & community services	Government services	Communities & community groups
• Sharing WoW activities with other government services			✓	
• Sharing WoW activities with local community and health services		✓	✓	
• Sharing WoW activities at local community network meetings that included both government and health and community service providers		✓	✓	
• Formative development of a not-for-profit organisation to deliver WoW activities on a fee for service basis (currently in recess)				✓
• Sharing WoW concepts and activities in community forums and sporting clubs		✓		✓
• Using WoW as a decision making tool for community activities				✓
• Using the WoW to help volunteer community groups structure governance and service delivery				✓

Education sector

Changes in health and wellbeing awareness and engagement, and practice, were evident in the education sector. There were clearly evidenced changes at organisational, and networks and systems levels.

Table 1 shows commonly reported changes in awareness and engagement, and practice, from education sector respondents. This data was sourced from qualitative responses in the practitioner survey, key stakeholder interviews, postcard responses, and depth interviews and focus groups with two schools.

It should be noted that only pre-school, primary school and secondary schools are represented here. No data was gathered from Universities, or Technical and Further Education (TAFE) providers.

Both education leaders, and the evidence base for wellbeing, were identified as important factors driving individual school and broader education systems awareness and engagement, and practice changes. Furthermore, the WoW was adapted specifically for use across education settings during the WCB Project; it is likely that contextualising WoW concepts and practices specifically to the education sector facilitated uptake at both an individual school level and broader educational system level.

The Principal Advisor – Mental Health Student Engagement and Wellbeing (North Coast region) was repeatedly identified as a WoW champion who worked hard to advocate for and systemically integrate WoW activities into education settings across the region. The work of setting specific WoW champions was also acknowledged as important to widespread uptake and ongoing momentum for WoW activities.

Health and community services sector

Changes in awareness and engagement, and practice related to mental health and wellbeing were evident in the health and community services sector. These were identified at both the organisational, and network, system and community levels. Interestingly, more systems level changes were identified than organisational changes; this may be the result of the depth data collection focus on two regional wellbeing hubs, as well as an individual community service.

Table 1 (above) shows commonly reported changes in awareness, engagement and practice from community service and health sector respondents. This data was sourced from qualitative responses in the practitioner survey, key stakeholder interviews, postcard responses, and depth interviews and focus groups from an individual community service and representatives from two regional wellbeing hubs.

Using the WoW conceptually also occurred at a systems levels where service collaborations to plan, coordinate and deliver services were using the framework. Understanding the evidence base for wellbeing was identified as an important factor driving awareness and engagement, and practice change, at both organisational, and broader networks and systems levels in the community and health services sector.

Government services

There were important changes related to health and wellbeing awareness and engagement, and practice, in government services. Organisational level changes were most evident, although important advocacy for the WoW was also occurring at network and systems levels.

Table 1 (above) shows commonly reported changes in awareness and engagement, and practice from government services respondents. This data was sourced from qualitative responses in the practitioner survey, key stakeholder interviews, postcard responses, and depth interviews and focus groups at one government service.

Our depth analysis identified strong engagement with, and uptake of, the WoW at a large government service. This included the widespread adoption of WoW activities across the service, including using short WoW activities and longer workshops, and incorporating WoW thinking and practice into staff induction, and training. Most staff at this large site had participated in WoW activities or workshops in some form. WoW language, concepts and activities supporting positive mental health and wellbeing were well embedded.

Responses from this service also identified strong advocacy from senior leaders for more widespread adoption of the WoW through the broader organisation in Queensland, and through the local community.

Communities and community groups

Changes in awareness and engagement, and practice related to positive mental health and wellbeing were evident in local communities and the community groups who support these communities. Many of these organisations were involved through regional wellbeing hubs.

Table 1 shows commonly reported changes in awareness and engagement, and practice from community groups. This data was sourced from qualitative responses in the practitioner survey, key stakeholder interviews, postcard responses, and depth interviews and focus groups from two regional wellbeing hubs.

More significant changes were evident at a network, system and whole of community level, rather than an organisational level. Repeated themes included using the WoW to frame community conversations about health and wellbeing, and as a decision-making tool about which activities to fund in local areas.

3.4 Effects on positive mental health and wellbeing

Data identifying individual positive changes to health and wellbeing amongst people receiving WoW activities was gathered through the project. There were three themes related to improved mental health and wellbeing through our data analysis although no pre and post testing of mental health status was conducted.

Firstly many respondents discussed improved psychological wellbeing through references to increased resilience, clearer sense of purpose, improved mood, calmer work and school settings and reduced anxiety and stress. Secondly, participants regularly identified improved relationships resulting from WoW involvement, this included improved family and friend relationships, improved relationships between work colleagues, and between teachers and students. Finally, the WoW appears to have encouraged an increased focus on physical health with many people discussing uptake of activities like walking, running, yoga and pilates. Healthy eating was also recognised as having improved for some people.

> The Men's Shed received a grant and they bought a pop-up tent with compartments, so they can have consultation rooms in it. The men can sit down with a health professional…I mean, in that environment they are doing that, they will sit down and have a prostate exam (depth interview)

Comments suggesting improvements in positive mental health and wellbeing included:

- *"A renewed sense of purpose, personally and at work"* (key stakeholder interview)
- *"Improved overall wellbeing"* (postcard)
- *"Schools reported so many positive impacts for staff wellbeing and resilience"* (key stakeholder interview)
- *"Teachers discuss calmer behaviour, looking for strengths in kids more than before"* (practitioner survey)
- *"We did pre and post testing… there were 14 questions around positive mental health… it shows people who go through the intensive program show positive shifts"* (practitioner survey)
- *"Helping children deal with anxiety and stress"* (postcard)
- *"Improved mood, improved physical as well as mental health"* (postcard)
- "*Being aware of my work and balance of relaxation, it has strengthened my wellbeing"* (postcard)
- *"You can visibly see changes in people. There's more camaraderie, people are more familiar and friendly with each other"* (depth interview)
- *"I think the mental health of staff has improved dramatically, students are also calmer after doing mindfulness, this is why we are doing the research with Smiling Mind in 2021"* (depth focus group)
- *There are people we know who have done the workshop, and then weeks or months later they've been at a time in their life where they've been on the brink of suicide. They've used what they learned in the workshop to get through and it's helped them* (depth focus group).

3.5 Conclusion: Awareness and engagement, and practice change

There was strong support for changes to positive mental health awareness and engagement, and practice, during this review. Participants believed these changes were the result of exposure to the WoW. Some

findings suggest that increased understanding and awareness about health and wellbeing facilitated engagement with the WoW, which in turn motivated practice and behaviour changes.

Changes were identified at individual, organisational, and network, system and community levels. Importantly, many participants believed that initial changes made at an individual level led to broader organisational and systems level changes as these people championed WoW thinking and practice in their workplace or broader setting.

Changes in awareness and engagement, and practice, were identified across all key sectors and settings targeted by the WCB Project (Education, Community and health Services, Business, Government, and Community).

The most numerous examples of increases in awareness and engagement, and practice change, came from the education sector in primary and secondary school settings. The WoW was being used to support school thinking about mental health and wellbeing at a conceptual level, and through widespread practical activities with teachers and students.

Health and community services were using the WoW in their own organisations, but also to plan and coordinate work with others, and this was having noticeable impacts in their local communities. Government services were also effectively implementing WoW thinking and practice, including integrating the WoW into workplace induction and broader staff development activities.

While individual changes were more numerous than organisational and systems level changes, it is clear the WoW has been integrated into organisations and broader networks, systems and communities. Advocacy for the WoW at a sector and systems level remains a strong focus for the project.

In considering these very positive results we should remain mindful that participant responses are likely to have come from those individuals and organisations with relatively greater impacts on awareness and engagement, and practice change related to positive mental health and wellbeing. Nonetheless, there is evidence to suggest new practice has been adopted, and practical improvements in mental health and wellbeing have resulted through participation in the WCB Project.

4 FINDINGS: EMBEDDING AND INTEGRATION OF CONCEPTS, ACTIVITIES AND RESOURCES

All sectors and settings targeted in this review have effectively implemented, embedded and integrated WoW concepts, activities and resources. There is evidence to suggest the WoW has been implemented and embedded across the education, health and community, government, and broader community settings at both organisational and broader systems levels.

> The cultural shifts organisationally have been noticeable (key stakeholder interview)

A key finding from the review was that the capacity to embed the framework was strongly influenced by the WoW's simple and flexible design, allowing it to be overlaid onto organisational models, process and practices, and adapted to specific setting requirements.

4.1 Usage and uptake

Consideration was given to the number of WoW workshops and activities run, and the uptake of these across different sectors and settings. WoW practitioners offer two discrete but connected workshops, a one-day introductory workshop and a five-day intensive workshop (DIY Happiness). They also provide one-off activities which relate to specific WoW elements or a combination of elements.

Set out below is data on the number of workshops and activities facilitated by WoW practitioners who responded to the practitioner survey. It is used to build a picture of the typical range and level of activity WoW practitioners engage in. Data on the number of people participating in each workshop or activity, and the timeframe in which workshops and activities occurred was not available. Workshop uptake occurred across the education, health and community, government and business sectors, and in the community.

Given approximately 20% of all WoW practitioners completed the survey it is likely that the total number of workshops and activities facilitated across the full WoW practitioner pool substantially exceeds the figures shown here. It is unclear if respondents to the WoW practitioner survey completed more, less or similar amounts of workshops and activities compared to those WoW practitioners who did not participate in the survey. It is also unclear whether the survey data on number of workshops excludes or includes the initial workshop that practitioners facilitate to gain accreditation following completion of the DIY Happiness Workshop.

Number of workshops and activities

One-day introductory workshop

The WoW is introduced via a one-day workshop designed to share key theory and science behind positive mental health and wellbeing, and which outlines the six key elements which make up the WoW (*People, Spirit, Place, Body, Mind* and *Planet*). This workshop aims to build awareness and engagement about the importance of wellbeing and the diversity of elements it incorporates. Both WoW advanced practitioners and WoW practitioners provide the one-day workshops.

TABLE 2: NUMBER OF ONE-DAY INTRODUCTORY WORKSHOPS FACILITATED

Number of one-day workshops facilitated by each respondent	Number of respondents (practitioners and advanced practitioners)	Total number of introductory workshops facilitated
None	**5**	**0**
1	**20**	**20**
2	**8**	**16**
3	**5**	**15**
4	**1**	**4**
Between 5 and 10	**5**	**25-50**
More than 10	**4**	**≥ 40**
TOTAL	**48**	**≥ 120**

Practitioner survey responses (n=48) showed that at least 120 one-day introductory workshops had been conducted by those completing the survey. Interestingly more than 50% (25/48) of participants had facilitated either one workshop or no workshops; it is unclear if these were new or existing WoW practitioners.

Five-day intensive workshop (DIY Happiness)

WoW intensive workshops are delivered by advanced practitioners. This program, known as the 'DIY Happiness Workshop' is a five-day program designed to put the theory and science of positive mental health and wellbeing (studied in the one-day program) into action. It also considers how activities might be implemented and embedded in local contexts and settings. The five-day workshop is typically run over a couple of months, allowing workshop attendees to practice what they are learning and bring reflections back to the group. As with the one-day workshops we do not have centralised data on the number of people participating or number of total workshops run. However, more than 80% (9/11) of advanced practitioners completed the survey so data here can be considered more representative of the total cohort, compared to the data for WoW practitioners (above).

TABLE 3: NUMBER OF FIVE-DAY DIY HAPPINESS (INTENSIVE) WORKSHOPS FACILITATED

Number of five-day workshops facilitated by each respondent	Number of respondents (advanced practitioners)	Total number of DIY Happiness workshops facilitated
1	**2**	**2**
2	**2**	**4**
3	**2**	**6**
4 or more	**3**	**≥ 12**
TOTAL	**9**	**≥ 24**

Advanced practitioner survey responses (n=9) to the number of five-day intensive workshops facilitated showed that at least 24 intensive workshops had been conducted by those completing the survey. Qualitative responses showed that five of the nine respondents had adapted the WoW intensive workshop to a specific sector (e.g. education), setting (e.g. alcohol and other drug rehabilitation centre) or population group (e.g. teachers).

WoW activities

WoW activities are delivered by WoW practitioners, and people who have participated in WoW workshops. Activities are provided to a wide range of people in diverse sectors and settings; these can be short, one off events focused around a single WoW concept or element (e.g. understanding the evidence behind positive mental health, running a mindfulness session, or making a 'gratitude jar'), or they may be ongoing activities that consider multiple WoW elements (e.g. school mental health week activities where a different WoW element is considered each day).

There were 48 practitioner survey responses to the question about how many individual WoW activities they had delivered. There was wide variability in answers to this question and this is understandable given some survey participants had been verified as WoW practitioners for longer than others. Table 4 (below) shows the number of activities (separate from workshops) run.Table 4

TABLE 4: NUMBER OF WOW ACTIVITIES DELIVERED

Number of WoW activities delivered by each respondent	Number of respondents (practitioners & advanced practitioners)	Total number of activities run (separate to workshops)
None	**5**	**0**
1 - 2	**6**	**6 - 12**
3 - 6	**11**	**33 - 66**
7 - 20	**15**	**105 - 300**
More than 20	**11**	**≥220**
TOTAL	**48**	**≥364**

More than 50% of WoW practitioners surveyed (27/48) had delivered more than seven activities, and more than 77% had delivered at least three activities. Only 10% of respondents had not yet delivered any WoW activities.

Sectors and settings adopting the WoW

Sectors that have adopted the WoW include education, health and community services, government, and business. The WoW has also been used in community settings like sporting clubs and volunteer organisations. The regional wellbeing hubs established by QMHC in 2016 have been important grounding points for the WoW, allowing dissemination into local communities and encouraging further uptake by health and community services in particular.

In the dataset available from the practitioner survey, many WoW workshops and activities were being undertaken in the education sector and most practitioners who responded to the survey had run at least one workshop in this sector. Primary schools were the most common education setting represented (50%), followed by secondary schools (33%). It is unclear if this emphasis on education is reflective of a greater focus on WoW activities in this sector or is an artefact of our survey sample. Many respondents had also run activities in health and community services, and more than 40% of participants (18/43) listed using the WoW in more than one sector or setting. One advanced practitioner ran workshops across four different sectors or settings (education, health and community services, government services, and community groups).

TABLE 5: SECTOR OR SETTING IN WHICH ADVANCED WOW PRACTITIONERS RAN FIVE-DAY INTENSIVE WORKSHOPS

Sector or setting	Number of five-day intensive workshops conducted
Education	**9**
Health and Community Services	**5**
Government Services	**2**
Business or workplace	**1**
Community Groups	**4**
TOTAL	**21**

Table 5 (above) shows the sector or settings in which advanced practitioners in the survey sample had delivered five-day intensive workshops.

People targeted for WoW activities

WoW practitioners responding to the survey were asked to identify their workshop and activity participants. Six groups were identified from the 47 responses provided. Many practitioners used WoW activities with more than one group. Responses from advanced WoW practitioners and WoW practitioners are combined in Table 6 below.[1]

TABLE 6: PEOPLE TARGETED FOR WOW ACTIVITIES

Groups targeted for WoW activities	Number of times listed
Staff (education, health and community, business, and government services)	**42**
Students	**15**
People using community and health services	**9**
Community groups	**8**
Parents	**2**
Businesses	**2**
TOTAL	**78**

Responses showed the majority of people targeted for WoW activities were staff (54%). The next most represented group was students (19%), while WoW activities were also being provided to people using health and community services (12%), community groups (10%), parents (3%), and businesses (3%).

[1] Two responses did not specify the groups they had targeted. These were 'run activities in schools' and 'secondary schools'. In these cases, responses have been allocated under both Staff and Students.

4.2 Helpful concepts, activities and resources

Participant responses showed uptake and use of varied WoW concepts, activities and resources which were thought to assist embedding the WoW in local settings. WoW practitioners also highlighted resources they were using to deliver workshops and activities, and to provide follow up support as important.

> [The WoW is] a really good decision-making tool. When we have a group of people coming together to talk about a project or service need, they ask questions about each domain of the wheel, so we can be holistic… The tool helps us know how much a project will have an impact on wellbeing (depth focus group)

Concepts

The WoW conceptual framework was important in WoW uptake with individuals, organisations and broader systems and communities. This included the evidence supporting the framework which gave workshop and activity participants confidence that the WoW could be helpful to them. The WoW framework was:

- **Simple to understand and share with others**, this was considered important to its widespread dissemination (See *Chapter 6: Transmission and ripple effects*).
- **Made up of six understandable elements** that helped in structuring thinking and practice. Participants reported that the elements made sense to them and were activity dimensions they could use to plan activities around, for both themselves and their workplace settings.
- **Based on a 'self-help model'** and 'learning by doing' approach. Workshop participants were encouraged to think about, and practically test how the WoW could assist them before sharing it with others. This appeared to encourage uptake and integration. Having seen demonstrable value personally, participants were motivated to promote and embed these ideas more broadly.

> You can't just jump into this you need to do it for yourself first. Once you see the benefits it's easy to share with others (practitioner survey)

- **Strengths-based**. Participants liked the health promoting and solution focused approach being espoused by the WoW. Some participants also felt it aligned well with their existing organisational service delivery models which assisted in integrating and embedding the WoW.

Separate to the conceptual frame created by the WoW our review identified five additional ways it was used conceptually. These have likely facilitated its integration and embedding into new settings. The WoW was used as:

- **A tool to audit strengths, assets and resources.** Multiple participants used the WoW to audit their current health and wellbeing. This was reported to assist because it helped people recognise the significant activities and resources they already participated in, and resources they had available to improve their wellbeing.
- **A planning and service coordination tool.** It is likely this has facilitated its integration and embedding into some systems and communities. Although not intended as such, the WoW was used to collaboratively identify needs, and plan and coordinate services. This led to a wide range of service providers, community members and funders having exposure to the tool and using it to

make collaborative decisions. These activities are likely to have been useful in further embedding the WoW across systems and communities.

- **A framework for service induction and training.** One service had organised significant elements of their induction and training program around the WoW, including developing two specific WoW training packages. Using the WoW as a framework for staff development is likely to have led to significant integration and embedding of key WoW thinking and practice in this organisation.
- **A service delivery framework.** The WoW was adopted by services as a way to conceptualise their service delivery approach, including implementation of more health promoting and strengths-based practices. Using the WoW as a service model is likely to embed key WoW principles and practices in these settings.
- **As a governance framework.** In one example the WoW framework was reported to have been used in simplifying and clarifying the governance framework at a Men's Shed.

> They used the WoW as a way to build up their Men's Shed. They built their governance and their practice model around WoW - they built it into their Men's Shed model (depth interview)

Spotlight example

One community has used the WoW as a decision-making tool to prioritise wellbeing activities and coordinate services. Regional wellbeing hub representatives reported developing a 'collaborative action plan' with more than 40 community and health services, and 80 community members and contract manager representatives from local, state and federal government. They believe using the WoW has assisted in breaking down barriers and developing agreed guiding principles bringing services, people and funding bodies together under 'one united action plan'. They now use WoW branding on all promotion.

Activities

Participants described an array of WoW activities which had been integrated and embedded into their individual, organisational or wider setting practice. Importantly many individual activities were first shared in WoW workshops and activities before they were more broadly socialised. The most commonly discussed activities included:

- Social connectedness activities
- Meditation, mindfulness and gratitude activities
- Yoga, tai chi and pilates activities
- Exercise activities, including walking
- Self-care reflections
- Support activities designed to help others

For a more comprehensive review of practice and behaviour changes, and activities being used as a result of WoW implementation, please see: *The impact of individual WoW elements* (immediately below) and *Section 3.2: Changes in practice*.

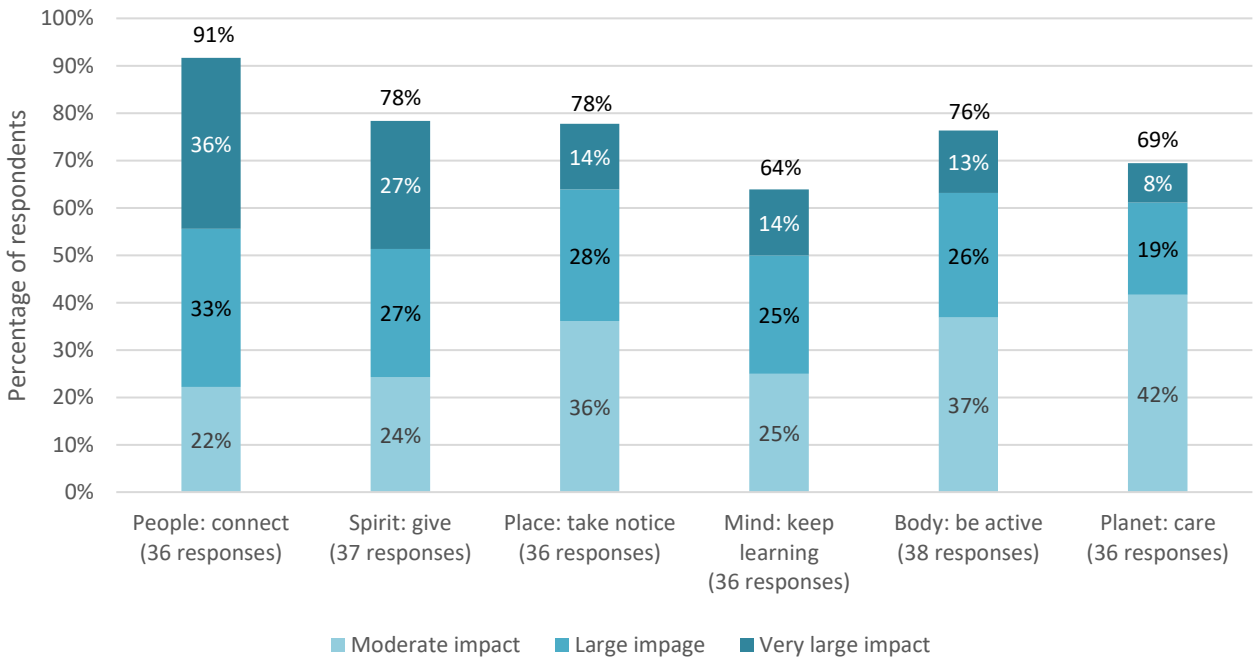
The impact of individual WoW elements

Participants completing the WoW practitioner survey were asked to rate each element (*Mind*, *Spirit*, *People*, *Place*, *Body* and *Planet*) for perceived impacts. Responses showing *'moderate', 'large'* and *'very large'* impacts are shown for each element in Figure 6.

Responses show that all elements of the WoW were thought to confer important benefits on positive mental health and wellbeing. *People – connect* was considered to have had the greatest impact, with 69% of respondents rating this as having a *'large'* or *'very large'* impact. Given the strong focus on relationships and social connectivity promoted in WoW workshops and activities this result is unsurprising. *Spirit – give* was also rated highly with 54% of respondents considering this had a *'large'* or *'very large'* impact, and many respondents discussed the importance of gratitude exercises and providing compliments as beneficial.

The lowest element rated as having a *'large'* or *'very large'* impact on positive mental health was *Planet – care* (28%), although the lowest overall impact when adding in *'moderate'* ratings was for *Mind – keep learning*.

FIGURE 6: PERCEIVED IMPACT OF WOW ELEMENTS



Analysis of breadth and depth qualitative findings related to each WoW element supports the WoW practitioner survey. This is shown in

Table 7 which lists commonly reported participant activity themes. It is acknowledged there is significant overlap between WoW elements, and this is shown in

Table 7.

TABLE 7: COMMONLY REPORTED PARTICIPANT ACTIVITY THEMES BY WOW ELEMENT

Activity	People	Spirit	Place	Mind	Body	Planet
Walks with friends	✓				✓	✓
Intentional family activities	✓	✓	✓	✓	✓	✓
Workplace social connection activities	✓		✓			
Volunteering and community participation	✓	✓	✓	✓		✓
Joining community groups	✓	✓	✓	✓		✓
Mindfulness and meditation				✓	✓	
Yoga and Tai Chi	✓			✓	✓	
Gratitude and compliment giving	✓	✓				
Healthy eating					✓	
Physical exercise	✓				✓	
New hobbies and activities	✓		✓	✓	✓	
WoW audits of health and wellbeing	✓	✓	✓	✓	✓	✓

Most activity themes included a connection to '*People - connect'*, participants often reported increased social connections and engagement through WoW activities. It appears this WoW element was important to respondents. All other WoW elements were also represented in the activities described and are consistent with practitioner survey findings.

Resources

Resources provided by the WCB Project were acknowledged as important to effectively implementing, embedding and integrating WoW concepts and activities for individuals, organisations, and to a lesser extent across whole systems and communities. These resources were viewed as essential to help structure thinking and practice.

Important resources were identified as:

- The **WoW diagram and tool**, which was considered effective in integrating the WoW flexibly across distinct population and cultural groups, sectors and settings, and into organisational cultures; the simplicity and flexibility of the tool was considered especially helpful in its uptake

- **Educational and activities information** provided by WoW practitioners in newsletters and other teacher and staff communications; this information was used with students, parents, community groups, and people accessing health and community services
- **The online WoW program** currently being trialled which allows anyone to log on and participate in WoW learning and activities
- **Specific WoW activities**, for example the 'marketplace activity' where participants had a short period of time to trial an activity across each WoW element, or 'circle practice' where participants 'check in' and 'check out' as part of group activities'; these activities were reported to have been adopted and adapted in different settings, for example workplaces, in a classroom with students, or as part of an organisational staff wellbeing day
- **Specific tools**, for example the 'smiling mind' app shared as part of the *Mind – keep learning* WoW element
- **A computer mouse pad** with WoW branding which helped remind staff to check in on their mental health and wellbeing
- **The WoW website** (wheelofwellbeing.org), although it was sometimes acknowledged that this was a less helpful resource given its international focus, slightly different WoW elements, and an older web interface.

WoW Practitioner resources

Practitioner resources were identified as important to effective implementation and integration of WoW concepts and activities. Many of these resources evolved as the project gained momentum, some are still in development or beta phase use.

Resources considered helpful to WoW practitioners were:

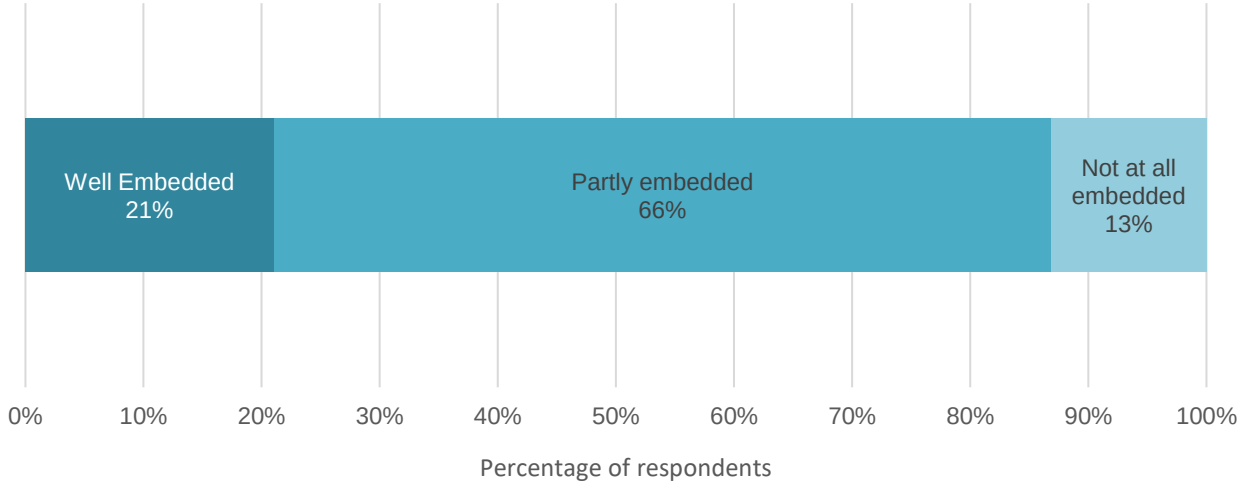
- **The manuals and templates** used to deliver both the one-day introductory workshop and five-day intensive (DIY Happiness) workshop
- **Tools and resources** which assisted in verification processes for WoW practitioners
- **Moodle**, the online platform developed to manage and catalogue positive mental health and wellbeing research and WoW articles, facilitate access to tools and other resources, and to support practitioners through networks and a newsletter
- **The WoW advanced practitioner group** that meets regularly to strategise further capacity building activities, share resources and provide collegiate support; this group is led by the WoW content developer (Implemental)
- Some advanced practitioners discussed how the **WoW Theory of Change** assisted them to understand how the framework was intended to build capacity and provide transmission and ripple effects into other settings.

4.3 Extent to which the WoW was embedded and integrated

There is a strong perception that not only have WoW concepts increased awareness about, and engagement with, positive mental health and wellbeing, but that these concepts have been effectively put into practice. There are multiple examples of activities being embedded into settings and organisations where WoW workshops and activities have occurred.

Figure 7 shows practitioner survey responses to the question of how well WoW actions and activities were embedded into organisations (n=38).

FIGURE 7: EXTENT TO WHICH WOW CONCEPTS AND ACTIVITIES WERE EBMEDDED



Nearly 90% of WoW practitioner survey respondents believed that WoW actions and activities delivered to organisations had been either been '*well embedded'* (21%), or *'partly embedded'* (66%). This suggests WoW activities have been implemented, at least in part, in most settings in which workshops and activities were provided. Examples of WoW implementation and integration into organisational culture, and broader systems and communities, are considered by sector or setting below.

Sector and setting specific examples

The review identified practical examples of how the WoW framework had been embedded and integrated into specific organisations, settings and broader systems and communities.

Education sector

The work of the Education Department Principal Advisor – Mental Health Student Engagement and Wellbeing (North Coast region) to champion WoW practice and encourage its further integration into the education system was repeatedly acknowledged. This individual assisted in adapting the WoW framework specifically for education settings (*Wow Ed*) and continues to advocate strongly for further use of the WoW within the Queensland Department of Education. These activities have likely assisted in embedding WoW thinking and practice in many school settings and raising awareness of the WoW across this region.

Breadth and depth data collection phases identified multiple schools, including both primary and secondary schools, where the WoW has been used to inform school vision, principles, policies and procedures. School code of conduct, and behaviour and wellbeing policies, have been adapted to incorporate WoW thinking and a strong focus of these adaptations has been consideration of different approaches to behaviour management which are more strengths and relationship focused.

> We incorporated WoW into our school vision – to have psychologically healthy students (depth interview)

Education sector representatives and teachers indicated that WoW activities had been integrated in school curriculum, for both staff and student wellbeing days, and in other extra-curricular contexts. School staff also reported the WoW being included as a standing agenda item at staff meetings.

> In a couple of schools... they've incorporated it into lots of policies and procedures – they even turned it towards staff to help their wellbeing and morale. Early days but they are embracing it (depth interview)

These findings suggest that the WoW framework is being progressively embedded into school settings, with considerable progress having been made in some cases.

Government sector

Depth data analysis completed with a large government service highlighted significant integration of the WoW framework into broader organisational systems and processes. This service had made a commitment to implementing the WoW, with most staff exposed to some positive mental health thinking and practice using the tool.

The service had integrated WoW into their induction and ongoing staff development activities, staff meetings and other social workplace activities. They developed both a 'WoW light' (introduction program) and a more intensive 12 - week program which staff could volunteer to participate in as part of their staff learning and development program.

> We have been linking WoW and positive mental health and wellbeing to all we do. It is used as overarching framework for our care practices (depth focus group)

Specific WoW groups had been established to facilitate positive mental health and wellbeing activities, both in the workplace and beyond it. For example, a walking group and a bring your garden to work day. These activities are intended to build relationships and morale in the workplace and are now common practice.

Depth data respondents suggested these initiatives had resulted in changed language, thinking and practices associated with mental health and wellbeing. The findings suggest strong integration of the WoW framework into this organisational setting.

Community settings and services

Depth data analysis with regional wellbeing hub representatives identified activities demonstrating integration of the WoW framework into community settings, and with community and health service providers and other volunteer community organisations. Importantly these initiatives were not identified just in individual services (although this was also true), but incorporated into broader networks, systems and communities which brought diverse stakeholders together under the WoW framework and brand.

> we can develop different governance systems, services, practices to benefit the whole community, we use the WoW as one of our tools (depth focus group)

The role of wellbeing hub coordinators was identified as important in sharing WoW resources and championing ideas into the community more broadly. These individuals were viewed as an 'expert resource' and WoW practitioners used them to strategically target organisations and plan WoW activities.

Examples were provided where the WoW framework was used to collaboratively identify local needs, plan activities, and coordinate service provision. In one example, a local primary health network funded data collection to help inform WoW activity planning. In another setting, data from a 'mental health and wellbeing impact assessment' was used to inform what WoW activities should be provided.

It was suggested that these activities had allowed a wide range of services, community members, and local, state and federal government funding providers to be exposed to the WoW and routinely use it for joint decision making. Respondents noted the WoW was being used as a commonly understood and accepted framework in some communities.

Furthermore, the WoW was reported as being used as a service delivery framework in two community settings, supporting its integration into community organisations. This was reported to have changed the language and frameworks that people were using to discuss mental health and wellbeing, with a shift to more health promoting frameworks and positive and strengths-based language.

> When we started, the perception around mental health was that it was all about when things were not going well. There have been dramatic changes to perceptions, people are drawing on the research and focusing more on health promotion and prevention activities (depth interview)

Together, these findings suggest strong integration and embedding of the WoW across a wide range of community and health services and community settings.

4.4 Factors helpful in embedding and integrating the WoW

The review identified the following factors as being important to implementation and embedding of the WoW:

- **Local leadership**, including School Principal and CEO support, and support from broader management and local champions
- The **number of WoW participants** completing workshops, with greater completions assisting integration and embedding. This was considered important in building and sustaining momentum for WoW thinking and practice, and sharing the load for providing WoW activities.
- **WoW facilitator motivation and energy** was considered important. End user respondents highlighted that excited facilitators fostered interest and engagement in others.
- **Time and resources** available to progress WoW thinking and practice. This included regular time for people who had participated in WoW workshops to complete further research using resources provided, practice skills learnt and run activities.

> Investments we made helped, three staff were trained. Two of our teachers are regularly released from the classroom to prepare and run activities (depth focus group)

- **Flexible use and adaptation** of WoW workshops and activities has made it easier to embed and integrate them across different settings, especially education, government and community settings. For example, *Wow Ed* has been specifically adapted for education settings, and tailored research, concepts and activities were recognised as important in gaining traction in the education sector. A 'Wow Light' and seven-week intensive program was created in a government service, using and adapting the WoW framework.

> The flexibility of the program easily overlays with other activities, we reduce content and change it for specific groups (depth interview)

- **Simplicity** of the WoW framework was repeatedly acknowledged as important to implementation and integration within existing organisational culture and processes. The fact the WoW could easily be overlaid with existing organisational service delivery principles and frameworks was viewed as a key strength.
- **Access to follow up support** was viewed as important in bedding down key WoW concepts, providing a 'cheerleader' function, and providing access to important resources.
- **Voluntary participation** was highlighted by one service as helpful in the uptake and integration of ideas. Staff who actively wanted to participate showed high levels of motivation to discuss and share their positive experiences with others.
- **Training local people trusted by their communities**, especially in more isolated and vulnerable communities, was considered a key factor for uptake and integration of the WoW in these communities.

The most successful WoW implementation processes occurred where organisations had strong leadership, committed staff time and resources to the process, had several staff working together to embed the WoW, were supported by local WoW champions, and were able to gain traction in using it with partner organisations or networks"

4.5 Barriers

Some barriers were identified which slowed the progression of WoW implementation and integration, especially during the COVID-19 pandemic in 2020. Commonly described barriers included:

- **A lack of leadership** or understanding in relation to the value of positive mental health and wellbeing in local organisations and settings (while acknowledging that organisations had provided time for staff to participate in WoW workshops and activities).
- **Insufficient resourcing** to effectively transmit and embed activities. Some respondents noted that you needed more than one staff member trained in the WoW to effectively drive practice change, while others commented on the costs of backfilling staff who presented WoW activities to other schools. A not-for-profit service intended to provide WoW activities

> Funding is an issue...we lost in funding and had to make this up ourselves. The program is resource intensive it costs about $500 to cover someone in our position to run a one-day WoW course. This is hard if we are regularly delivering to other schools, which I would like to do more (depth interview)

could not continue in part due to a lack of start-up funding (see spotlight example below).

- **Competing time and resource pressures**, especially in schools where a busy curriculum often made it hard to find time for other activities. It was also suggested that some schools were difficult to access or unwilling to dedicate time to further embedding the WoW.
- **The need for more sophisticated communication and promotional activities** to 'sell' the WoW into new settings (e.g. schools) or with different population groups (e.g. parents) was discussed.
- **Type of service provided** was an identified barrier at some community services. These services highlighted difficulties in re-framing staff perceptions around mental health and wellbeing while working in a crisis service. This was a barrier at two levels, firstly because staff felt they had insufficient time to undertake WoW activities on top of their busy work schedules, and secondly because of the presenting situations of the service users they were supporting who tended to have many immediate needs in areas such as housing and family violence. Some, but not all participants believed this reduced the capacity to embed the WoW in these settings.
- **COVID-19** reduced the capacity to provide WoW activities in all sector settings, especially activities being run in the community. Multiple examples were provided where regular WoW groups had to cease and this slowed momentum. WoW activity groups related to cooking, walking, community markets and artistic activities were all reported to be impacted by the COVID-19 pandemic, as were groups in organisations which sometimes went online.

> COVID really hurt us. We had $50,000 worth of income lined up that would have enabled us to get the workshops back into the communities, we couldn't use it (depth interview)

- **Loss of WoW advanced practitioners** who moved on to different roles, started families, or moved out of a geographical area was a barrier to further transmission of the WoW. Because the advanced practitioner intensive course (DIY Happiness) is a five-day program, typically run over a number of months, with limited places available, it is difficult to quickly fill these roles when someone leaves.

> We've lost a couple of advanced practitioners too. One got pregnant, one moved away… This is a huge region (depth focus group)

- **The distances across rural and regional Queensland** were recognised as a barrier to further transmission of WoW thinking and practice. It was noted that some advanced practitioners covered wide geographies that spread them very thin on the ground. Demand for WoW activities often exceeded capacity in in these cases.
- **Lack of structure and follow up support.** While many highlighted the benefits of a flexible WoW framework, a few respondents felt lack of structure made it hard to implement activities in their local settings, both organisationally and in the community. Others would have liked more follow up support (although many more respondents felt they were very well supported).

Spotlight example

Following completion of the five-day (DIY Happiness) WoW workshop by seven participants in one local area they identified the need to find a sustainable method to continue transmitting WoW thinking and practice more broadly across the region. This led to a plan to create a not-for-profit service that would facilitate WoW activities to other services and communities by running workshops and activities on a fee for service basis.

Discussions with one representative involved in this idea stated that both COVID-19 and a lack of ongoing funds had reduced their capacity to progress this idea.

4.6 Unintended consequences

Some unintended consequences, both positive and negative, were identified during the WCB Project Review. These are listed below.

- **Relationship development activities** were reported to have been significantly strengthened through using the WoW in some organisations and communities. While the WoW has a focus on social connection as a key element (*People – connect*), it appeared to create further opportunities beyond this for staff who might not ordinarily spend time together. Staff who worked different shift times in a large government organisation were reported to make connections and the WoW was also considered helpful as a way to build other organisational relationships through lunchtime conversations and activities staff participated in outside the workplace. The WoW was also helpful in bringing diverse organisations and people together.

> People are making more connections which is great because we are a big organisation… more friendly conversations. Especially when people who come together in workshops are from different areas or work different shifts. We are seeing social groups forming out of participants in WoW activities (depth interview)

- **Collaborative working** was reported to have been significantly improved in some local communities by using the WoW as a service planning and coordination tool. It allowed service providers with different funding and outcome focus areas to prioritise activities and coordinate work. While the WoW was not intended to be used as a planning and service coordination tool, in some cases it has provided a helpful unifying framework.
- **Using WoW resources for COVID-19 support** was appreciated by teachers and parents. These resources were shared to support parents with home schooling activities.

> We were able to pivot quickly when Covid came, we used online and newsletters to push info and resources out to parents (postcard)

- **Access to other learning opportunities** was recognised by a government service who offered WoW activities to an Aboriginal Community Controlled Organisation. WoW facilitators learned important things about Aboriginal culture by participating in an Aboriginal women's talking circle while simultaneously sharing WoW resources.

- **Overdemand** was an unintended consequence of sharing information about the WoW. In some settings demand for workshops and activities outstripped capacity to provide them. This meant some people who had heard about the WoW and wanted to participate could not. This was particularly the case in the community and health sector, as well as the education sector where there were unmet costs for backfilling staff.

> [There have been] lots of requests from the community to have us come and speak and do activities. They are requesting further support… but sometimes we can't keep up (depth interview)

4.7 Sustainability

While not a focus of the review, some participants provided reflections on how to sustain the important gains made during the WCB Project once seed funding from QMHC ceased.

It was acknowledged that developing and delivering the WoW was resource intensive and that there were costs for organisations participating in workshops. Significant financial investments have been made in developing WoW resources, including resources for WoW practitioners and those attending the workshops and activities. Furthermore, running workshops, especially five-day workshops, is costly. Organisations who committed to participation in the WCB Project also subsumed significant costs, this included costs for backfilling staff, developing bespoke materials for their specific setting, providing ongoing time to plan and run WoW activities locally, and to share the WoW framework with others in their local communities.

While these initial costs appear high, the WCB Project recognised that development of WoW resources and training of WoW Practitioners would have important flow on effects and benefits beyond the QMHC funding period. This includes the continued sharing of WoW thinking and practice, both intentionally and organically. It is likely that for every WoW workshop participant, many others have and will continue to receive free WoW information, resources and activities.

Nonetheless, if the WoW is to continue being implemented and shared it will be important to consider a funding model which can support this. Two possible models emerged during the review. One model could be described as a 'sector pays' model, while the other was a 'user pays' model.

The **'sector pays'** model would aim to identify funding from a key government department or significant philanthropic provider to strategically roll out the WoW within a given sector. The education sector may be a good candidate for a model like this. This approach could include employment of dedicated WoW practitioners who offered free training and follow up support to schools and other education settings. This approach may include financial incentives to participate that allowed for backfilling of classroom teachers and specific content development relevant to the setting. This model would require close alignment with broader sector wellbeing strategies and activities in order to be funded.

The '**user pays**' model would ask those receiving the benefits of the WoW to pay the costs of training and development. While the upfront costs to individuals and organisations would be significant, there is an argument to suggest that these costs would be recovered over time through things like reduced stress and staff turnover, reduced behavioural problems, and increased productivity. This approach would require strategic promotion and further development of resources demonstrating the evidence base behind WoW thinking and practice to encourage organisations to pay for WoW courses.

Both funding models are consistent with QMHC's initial plan to invest in partnerships and provide seed funding that would contribute to developing sufficient momentum for the project that it could become self-replicating. It was noted that future costs in delivering the WoW would be reduced because:

- Workshop resources, including both facilitator and participant resources had already been developed
- Moodle, the online support and resource for WoW practitioners had already been developed
- Online WoW courses were being trialled and could be expanded, perhaps reducing costs associated with facilitator time, travel, venues and catering.

4.8 Conclusion: Embedding and integrating the WoW

WoW practitioners responding to this review reported providing more than 500 workshops and activities. These were most commonly provided in the education, and health and community services sectors. Staff and students were the most common recipients.

A wide range of WoW concepts, activities and resources were shared during the project; many were reported to assist implementation and integration into new settings. Helpful conceptual elements of the WoW framework include its evidence base, six elements, simplicity, perceived value to original workshop participants, and strengths-based approach. Participants used activities shared in Implemental workshops across each of the six WoW elements; the most commonly referenced elements were: *People – connect; Spirit – give; and Body – be active.*

Resources were considered valuable in embedding new practice and behaviour. Helpful resources for participants included the WoW tool and diagram itself, the activities (and associated tools) shared in workshops, links to other resources, the WoW online program, and the WoW website. Helpful resources for WoW practitioners included the workshop manual and materials, the WoW Practitioner Group, Moodle – the online support platform, and the Theory of Change developed for the project.

Participants believed the WoW had been at least partly embedded in most settings it was introduced. This included integration into organisational cultures, processes and practices, and broader uptake across networks, systems and communities.

WoW advocates and practitioners in the education sector had undertaken significant systemic work to integrate the WoW, including development of a five-day intensive *Wow Ed* program. Individual schools reported strong uptake and integration of WoW concepts into school values and policy development. Activities were incorporated into both structured curriculum and extra-curricular activities. WoW participants also worked hard to further disseminate WoW thinking and practice across other education settings.

Detailed review of a government service identified adoption of the WoW framework to structure induction and training, and to develop groups and workplace activities which facilitated social connections and self-care. This service also worked hard to systemically share their WoW practices with others in their local community and in their broader organisation.

Community and health services working in local communities effectively used the WoW as a tool to audit, plan and coordinate their work. This had significant benefits in exposing a wide range of services and

community members to the WoW. Some volunteer community services embedded the WoW as a service delivery framework.

Key factors considered helpful in embedding the WoW were: organisational leadership; the number of WoW practitioners trained; the energy and motivation of practitioners; time and resources dedicated to the WoW in local settings; and the flexible, simple nature of the WoW itself.

Perceived barriers to further uptake and integration included: a lack of resources in local settings; the loss of advanced practitioners, significant travel distances for practitioners in regional areas; and the COVID-19 pandemic.

Both positive and negative unintended consequences of WCB Project participation were identified during the review. These included: additional relationship development opportunities; collaborative working opportunities; support to parents and community members during COVID-19; access to additional learning opportunities; and over demand for WoW presentations and activities.

There is good evidence to suggest the WoW has been effectively implemented and embedded across a range of sectors and settings, however sustaining and further developing its implementation will require identification of new funding, some possible models for this are emerging.

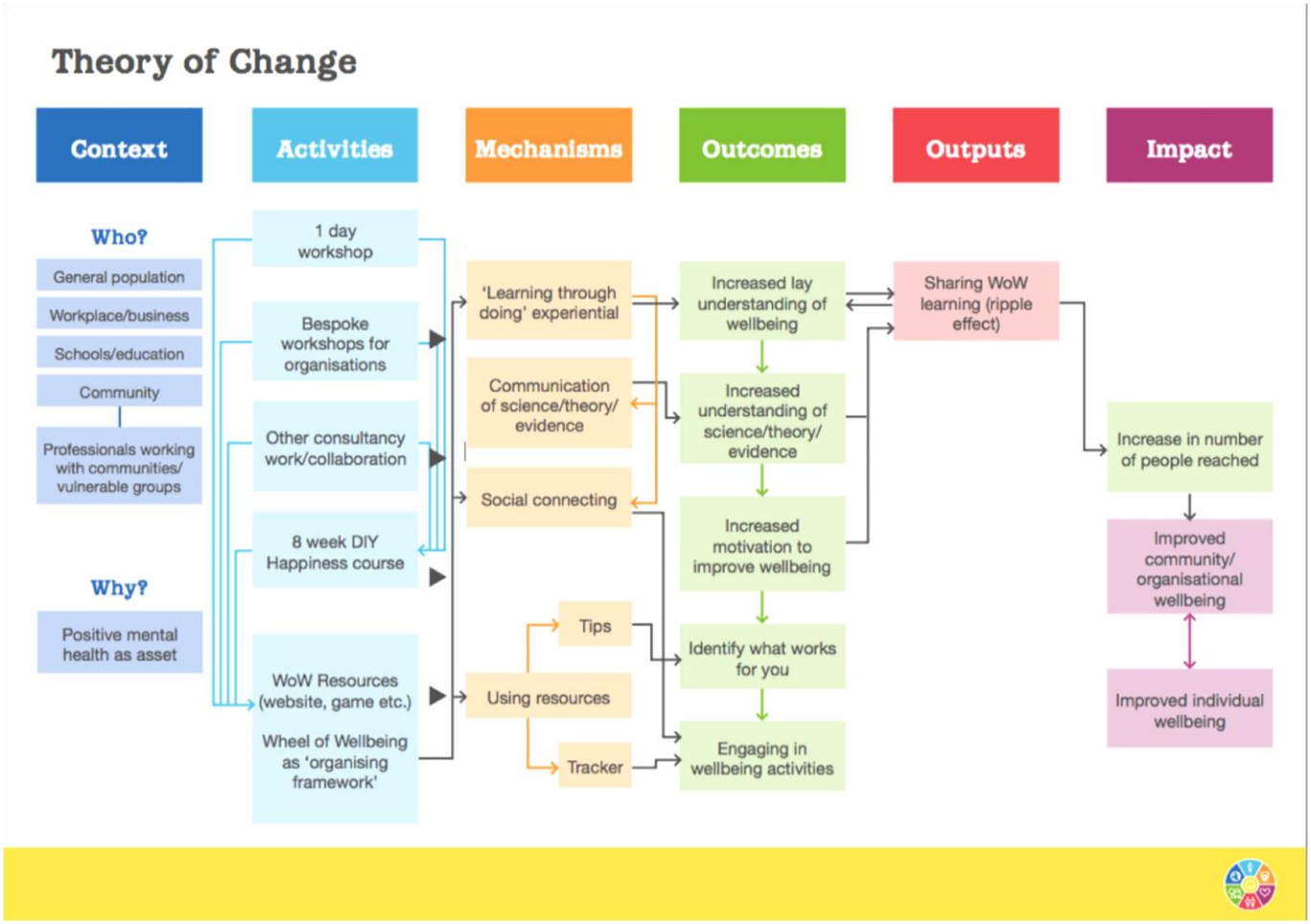
5 FINDINGS: MODEL ELEMENTS ENABLING DESIRED OUTCOMES

Information related to the WCB Project capacity building model was provided by the WoW content developer. Additional information about the most helpful capacity building elements was gathered through key stakeholder interviews, depth stakeholder consultations and the practitioner survey. There was strong consistency in the capacity building approach being used across distinct sectors and settings.

5.1 What capacity building model is being used?

Outlined below, in Figure 8, is the WoW Theory of Change (ToC) developed by Implemental to show how the WCB Project is hypothesised to create the outputs, outcomes, and impacts sought. The ToC describes how WoW workshops and activities, knowledge and practice development, resource sharing, and support to settings builds positive mental health and wellbeing at an individual, organisational and community level.

FIGURE 8: WOW THEORY OF CHANGE



Note: The '8-week DIY Happiness course' shown in the WoW Theory of Change above has now been developed into the five-day DIY Happiness Workshop discussed throughout this review.

Capacity building phases

QMHC structured the WCB Project in key phases designed to build individual, organisational and systems and sector capacity. The initial project phase was focused on building awareness and engagement around positive mental health and wellbeing, and the WoW framework. During phase two there was a focus on strategic activities aligning the WoW and regional wellbeing hubs to build community wide wellbeing initiatives. Finally, a third phase focused on strategic engagement of the education sector, including the early childhood education sector.

The WoW Support Program (also funded by QMHC) assisted phase two and three initiatives by providing financial support to further develop, manualise and streamline WoW training and resource materials, adapt WoW materials to specific sectors and settings, and coordinate and deliver training more broadly. It also provided funding to train Department of Education Mental Health Coaches working in schools.

Most important capacity building elements

Interviews with the senior WoW content developer (n=1) and WCB Project champions (n=2) broadly supported the Theory of Change shown above; they believed the model provided a good representation of how the WoW was effecting change in individuals and organisations. Broader interviews also supported the change model with strong consistency from participants about the most important ToC elements.

The activities considered most important were:

- **The WoW workshops** (and manuals structuring these workshops) which provided a stepwise introduction to, and opportunities for, implementation of activities using the WoW framework back in local settings. The simplicity of activities shared in workshops was acknowledged as important in building motivation and capacity to share concepts and activities, which facilitated 'ripple effects' into new settings.
    - The one-day introductory workshop was described as helpful in setting the scene by sharing key theory, science and simple activities
    - The five-day intensive DIY Happiness workshop was described as important to enacting activities and building confidence through a 'learning by doing' approach.
- **Resources** – The resources available to WoW practitioners (e.g. Moodle, workshop manuals, support networks and newsletters) and WoW participants (e.g. Marketplace activity, 'circle practice', links to key apps and other tools) were recognised as helpful in building capacity in local settings. The former to structure and support practitioner facilitation activities, and the latter as a way to easily facilitate uptake of specific activities (e.g. mindfulness using the 'smiling mind' app).
- **Tailored activities** – The capacity to tailor activities to specific settings and population groups was viewed as a key strength of the capacity building model. This was recognised by participants as helpful in engaging particular groups and adapting activities to specific settings, especially education settings where activities were adapted for distinct developmental ages and stages. The WoW has also been adopted in Aboriginal cultural contexts, with young people, and with those in aged care. Five advanced practitioners reported adapting WoW DIY Happiness Workshops for specific groups, including a drug and alcohol rehabilitation program.

The mechanisms considered most important were:

- Sharing the **science/evidence/theory** behind the WoW, which was recognised to give it credibility, especially for professionals, and this facilitated acceptance of the WoW framework
- The **learning through doing** approach (see also 'do it for yourself first' below) which highlighted the value of testing out activities yourself before sharing them with others
- The relational focus of the program which highlighted **social connecting** and opportunities to further build networks and relationships; this was recognised as important to further dissemination and implementation of the WoW.

> You need to have a critical mass doing the program, once you get to a tipping point it really takes off (practitioner survey)

Theory of Change outcomes and outputs are not discussed here as they are examined in Chapters 3, 4, and 6 of this review.

Existing capacity building elements not included in the ToC

A number of additional capacity building elements not currently listed in the ToC were identified through the review. It may be helpful to incorporate these into any refinements made to the ToC as participants frequently recognised their contribution.

Additional existing capacity building elements included:

- **Do it for yourself first** – The importance of understanding and using the WoW for yourself first, before sharing it with others, was highlighted. This factor focused on the motivation and excitement that was generated in workshop participants who saw real value in the WoW for themselves, which in turn encouraged them to share it with others and implement it back in their local settings.

> Concentrate on yourself, then things ripple through to the team naturally. My work on myself has helped my team (depth focus group)

- **Strengths-based** – The WoW capacity building model was described as 'strengths-based' and this was identified as important to implementation and uptake. Not only does the WoW share positive health promoting activities, it also works as a tool to audit existing assets and resources. This strengths-based health promoting approach was seen as a key WoW element.
- **Simplicity and flexibility** – Respondents suggested that the simple and flexible nature of the WoW framework made it accessible and easy to use, which in turn facilitated uptake and this should be recognised in the ToC.
- **Diverse channels and activities** – Respondents suggested that that the varied activities and channels available helped build WoW capacity. For example, WoW thinking and practice could be shared via a short activity, one-day workshop, or five-day intensive, and it could be provided through individual coaching and mentoring, in

> WoW is such an accessible, universal approach that people intuitively respond to it and seem to find it easy to relate to and use. It had great 'face validity'! The thorough support for the WoW Intensives, with the verification process, seems to have really helped to embed WoW in people's lives and work (practitioner survey)

larger group settings, via face to face activities or online.

- **Advanced practitioners** – These practitioners were an added support component to the WCB Project and were identified as necessary to effective roll out of WoW thinking and practice. They were perceived to have an important support function and deeper level of knowledge about the WoW. They were described as providing an important 'backbone' to the WCB Project and some participants felt they should be noted as key mechanisms for change in the ToC.
- **Train the trainer and follow up support** – The 'train the trainer' model, including a verification process for people completing WoW activities, is another new element of the capacity building model considered important in maintaining fidelity to WoW concepts and activities. It may therefore be worthwhile including this in future ToC diagrams.

Finally, while not specifically a 'capacity building element' the **support provided by QMHC** in the rollout of the WoW was consistently recognised as fundamental to its success. This included funding for WoW activities, integration of WoW activities in regional wellbeing hubs (including funding of hub coordinators) and across other settings (e.g. the Education sector). QMHC was viewed as an important catalyst for broad promotion of the WoW and opened doors to key sectors.

> QMHC's commitment over a period of time and ability to connect across networks was important... funding and extension of funding, the understanding that building relationships and networks in communities takes time has been integral (practitioner survey)

Possible future capacity building factors

Participant responses supported the operating WoW capacity building model. However, additional factors for future consideration were also identified. Participants believed these factors may further improve model roll out and success.

Possible future capacity building focus areas included:

- **Better strategic engagement with the Department of Education**, especially Central Office, to build on the significant momentum already attained
- **Broadening WoW networks and other support structures** through platforms such as webinars or other information sharing and support activities, online and face to face
- **Further exploring WoW online courses** and evaluating their effectiveness in broadening WoW reach and transmission effects
- **Increased strategic marketing and promotion** of WoW, including case studies to celebrate positive outcomes and build broader organisational and community wide interest and engagement in positive mental health and wellbeing.

5.2 Conclusion: Capacity building

The WoW capacity building model aims to increase individual and organisational wellbeing. It was well supported by review participants who believed the model was operating as intended, although some participants acknowledged the current model was costly.

Participants believed the most important capacity building activities were the workshops and resources provided by Implemental, and the capacity to tailor activities to specific settings and populations. Mechanisms recognised as important were sharing the science and evidence behind the WoW, the learning through doing approach, and opportunities for social connecting.

Additional capacity building factors were identified that could be incorporated into future models. These included the do it for yourself first approach, the strengths-based approach, channel and activity diversity, and advanced practitioners.

Some participants suggested future areas for focus that might provide even more impact to the model. These included more strategic engagement with key sectors and settings, broadening support networks, increasing online WoW activities, and increased marketing and promotion of WoW success stories.

6 FINDINGS: TRANSMISSION AND RIPPLE EFFECTS

A fundamental component of the WCB Project is the expectation that WoW participants will take their WoW learnings and share them back in their local settings and communities, 'paying forward' the benefits they have accrued themselves.

The WCB Project Review identified two important mechanisms by which this was occurring; they have been defined as 'transmission effects' and 'ripple effects'. These effects have been noted to occur both vertically and horizontally. Definitions for these terms are provided in *Section 2.3*.

6.1 How were you introduced to the WoW?

The WCB Practitioner Survey asked participants how they had become aware of the WoW. This provided an indication of the range of settings the WCB Project engaged. While it does not necessarily speak to transmission and ripple effects flowing from participation in WoW workshops and activities, it does provide information about the pools within which these transmission and ripple effects were instigated.

There was wide variability in the qualitative responses to this question, with some people describing a communication channel (e.g. email), others the setting (e.g. school), and still others particular people (e.g. my manager). Responses to where people first became aware of the WoW have been consolidated under key themes identified in Table 8 below.

TABLE 8: WHERE WERE YOU INTRODUCED TO THE WOW?

I first became aware of the WoW through:	Number of responses
My workplace or school	53
A network or regional system	11
A manager or colleague	10
My community	8
A communication channel (e.g. newsletter, email or social media)	6
A Mental Health Coach	3
TOTAL	**91**

Most people were introduced to the WoW at their work or school (69%); this figure combines responses for 'manager or colleague' (11%) and 'workplace or school' (58%). 'Networks and regional systems' (12%) and 'community' (9%) were also repeatedly described as settings for initial introduction to the WoW.

6.2 Transmission and ripple effects

Following participation in workshops and activities, participants were asked how they shared the WoW with others, including family, friends and colleagues (individuals), organisations, and in broader networks systems, and communities. These responses have been categorised as either 'transmission effects' (structured and intentional sharing) or 'ripple effects' (organic and informal sharing).

A wide range of different transmission and ripple effects were identified by participants. The WCB Project has been successful in providing exposure to WoW thinking and practice well beyond those who participated in initial WoW workshops and training.

Strong initial engagement by workshop participants appears to have facilitated WoW implementation in a wide range of settings and with diverse population groups. There are many examples where individuals have shared WoW thinking and practice in both structured and unstructured ways, allowing others exposure to key concepts and activities. In multiple cases, one or two people attending a workshop has led to widespread uptake of WoW thinking and practice across an entire organisation. On some occasions, these organisations have then worked to disseminate the WoW more broadly through their networks and systems.

Transmission effects

Structured and planned transmission of WoW thinking and practice to other individuals, organisations and networks, systems and communities was diverse. All WoW practitioners interviewed or participating in focus groups described strategic attempts to share what they had learned with others.

Individually

Transmission effects were less evident on an individual basis and this is not surprising as most WoW activity sharing occurred with groups. However, some people described structured and intentional individual WoW sharing activities. These transmission effects were almost always horizontal in their effect (being carried from one setting to another). Most often people completed WoW workshops to use in their organisation, system or community, but then also applied these learnings elsewhere. Examples of individual transmission effects included:

- A family structuring weekly activity that would promote their health and wellbeing. One respondent described a weekly family meeting where an element of the WoW was the chosen focus and then low or no cost community activities were identified that aligned with this element. They developed a workbook of activities over time (horizontal transmission).
- Multiple participants described using the wheel to plan structured conversations with intimate partners and using the WoW to improve their relationship dynamics. This included identifying shared activities and using these as a means to improving communication, as well as individual wellbeing (horizontal transmission).
- The development of walking groups and mindfulness groups. This included scheduled activities with friends and work colleagues with an intentional focus (horizontal transmission).

Organisationally

There were many examples of using the WoW to transmit positive mental health and wellbeing concepts and practices at an organisational level. Many organisations encouraged staff to undertake WoW training in order to deliberately bring back ideas for use in their organisational setting, which were then shared in many different forms. In organisations where WoW practice flourished, multiple staff members were engaged and motivated by WoW thinking and practice which provided significant momentum.

Examples demonstrating the intentional and structured transmission of the WoW framework included:

- Using the WoW to frame higher order school foundational principles, policies and procedures (vertical transmission)

- The provision of dedicated WoW induction and workplace training (WoW Light Program and WoW 7 Week Program) opportunities for staff at a government organisation and a community services organisation (vertical transmission)
- Sharing the WoW with teachers and students through planned activities; for example, creating specific curriculum around mindfulness that was then shared with all teachers in a primary school, or using the WoW to frame staff and student wellbeing days (vertical transmission)
- A school shifting focus to transferring Wow activities already embedded in their primary school into their middle school by introducing activities with both students and teachers there (vertical transmission)
- Introducing 'fun activities' such as a bring your garden to work day, or show off your pet day which were designed to improve social connectedness, even for individuals who had no prior exposure to the WoW (vertical transmission).

Networks, systems and communities

Following integration and embedding in their own organisations, many WoW practitioners created learning opportunities for other organisations, networks, systems and communities. For instance:

- Adoption and adaptation of the WoW (*Wow Ed*) for the Queensland Department of Education (vertical transmission)
- Discussions with executive management of a government service to systematically expand WoW adoption to other organisational services in the region (vertical transmission)
- Using the WoW to prioritise, plan and coordinate work with over 40 community and health service providers, 80 community members and local, state and federal government funding bodies (vertical and horizontal transmission)

> I've run 5-6 workshops in the community now. We invite community and government services (depth focus group)

- Supporting volunteer community agencies to use the WoW in developing governance and service delivery frameworks (horizontal transmission)
- Providing whole of organisation 'WoW tasters' (introductions) in community and health organisations (horizontal transmission)
- A government service offering WoW activities to other community agencies, for example an Aboriginal Community Controlled Organisation and a disability service (horizontal transmission)
- Community services offering WoW activities to volunteer community groups; for example, 'wellbeing days' with older groups in the community which included recruiting people at the Returned Services League (RSL) and Probus Club (horizontal transmission)
- Presenting a 'WoW day' to 50 local area school principals (vertical transmission within the Education system)
- Inviting other schools to observe WoW activities in a school already utilising the WoW (vertical transmission within the Education system)

> We invited staff from five or six schools to come and look at what we were doing… There was great take up, some schools have asked me to run workshops (practitioner survey)

- Adoption of the WoW by mental health coaches, school nurses, youth workers and welfare officers in schools and other settings following WoW information sharing at network meetings (vertical and horizontal transmission)
- Adoption of WoW thinking and practice into an environmental organisation following participation in WoW activities run by a health and community service (horizontal transmission)
- Adaptation of WoW activities into a Peer Support Program with the support of another community service organisation (horizontal transmission)
- Running WoW groups for vulnerable community members (horizontal transmission)
- Sharing WoW thinking and practice at professional conferences and forums (vertical and horizontal transmission)

> An outstanding example is [organisation]… two staff who had attended a one-day WoW… started to run their own programs on a regular basis, with significant impacts in their community. Notably, they had experienced significant individual benefit which led them to adopt WoW for the vulnerable families with whom they worked (practitioner survey)

- Sharing and using the WoW at a region wide schools' network and promoting it through their newsletter (vertical transmission)
- Community groups (e.g. Rotary Club, Men's Shed, Country Women's Association) requesting WoW workshops and activities after reading about the WoW through a regional wellbeing hub newsletter (horizontal transmission)
- Introducing WoW thinking and practice at a community reference group meeting (horizontal transmission)
- Development of annual community wellbeing days (horizontal transmission).

Ripple effects

While planned and structured transmission of the WoW was widespread, so too was a more organic and informal sharing that effectively disseminated ideas and practices across different settings and population groups. These ripple effects were more subtle and opportunistic but considered equally valuable as they often occurred through trusted friendships and communication channels. This was thought to improve interest and uptake in the positive mental health and wellbeing messages being shared.

> From me to friends, from friends to their families, from these families into their communities, Scouts, the footy club (depth interview)

Individually

WoW workshop and activity participants described sharing concepts and activities learnt with family, friends and colleagues in an informal manner. They often identified specific activities or aspects of the WoW they felt would resonate with others they knew, rather than sharing the entire WoW framework. Some people adapted WoW activities for their children and partners.

> I've seen WoW ripple out from me to staff, from staff to students, from students to parents (depth interview)

Some examples of ripple effects reported for individuals included:

- Students developed their own personalised 'mindfulness scripts' and in some cases took them home to share with their family (horizontal ripple)
- Using gratitude activities at family dinner time (horizontal ripple)
- Lunchtime or dinner party conversations about the science behind positive mental health and wellbeing with colleagues, family and friends (vertical and horizontal ripple)
- Sharing WoW resources like the 'smiling mind' app (horizontal and vertical ripple)
- Using the WoW opportunistically following family and community misfortune (horizontal ripple)
- Sharing resources with individual parents during the COVID-19 pandemic; original resources were not intended for parents (horizontal ripple).

Organisational, and network, system and community ripple effects

Although most WoW sharing within and across organisations, networks, systems and communities was planned and structured, there were also examples where the WoW rippled into new settings more organically.

An important example of this was role transitions facilitating exposure to the WoW in new organisations (vertical ripple within education system). One primary school principal who had previously embedded the WoW in a primary school then adopted it when moving to a new school, while others moved to new community-based organisations and used WoW activities they had previously learnt with their new employer.

A second broader ripple effect occurred through 'word of mouth' dissemination in local communities, and community groups (horizontal ripple). There were examples provided where people who were introduced to a WoW activity at a local community market or network meeting then took this information back to their work colleagues, organisations and local community clubs. This 'word of mouth' approach created so much interest in some communities that WoW practitioners were unable to meet demand.

> I've seen it spread like weed over the islands, a good weed. One group talks about it to another group, they try it then next thing you know another group is doing it too. It's a small regional community people are tightly connected (depth focus group).

> After I bought it home my daughter loved it, she is sharing it with her school friends now, it has jumped from my school to my daughter's school through our family (depth interview).

> Country Women's Association, Rotary Club, other NGOs have approached our group to enquire on running activities and workshops in the community after hearing about it in their workplaces or at community events, we can't keep up with demand (practitioner survey)

6.3 What pathways supported transmission and ripple effects?

A wide range of pathways have facilitated transmission and ripple effects, allowing exposure to the WoW framework in new sectors and settings; this included both vertical and horizontal pathways (see definition above).

Education system structures and networks provided important pathways to transmit the WoW framework. These pathways were used by school principals and mental health and wellbeing officers to promote the WoW. Teachers used local groups to share thinking and practice with other education specialists, and more broadly with youth networks. The WoW was adapted specifically for education settings (*Wow Ed*) and this was viewed as important to supporting uptake and embedding of WoW thinking and practice across education services.

> The benefit of the networks brought together by QMHC under the banner of WoW have been incredibly valuable to individuals attending and the networks [and] settings they represent (practitioner survey)

Regional wellbeing hubs were viewed as potent transmission points where interagency activities and community forums facilitated opportunities to share the WoW with diverse people, organisations and community groups. These settings allowed momentum building in local communities with wellbeing hubs acting as important repositories of support and resources for broader WoW promotion and activity. These pathways often had a potentiating effect where transmission and ripple effects gained significant momentum in local communities to such an extent that demand for WoW activities outstripped capacity to provide them.

WoW practitioners and champions working at systems and community levels were identified as important conduits to sharing the WoW into new settings. WoW practitioners had both high-level content knowledge related to the WoW and a strong motivation to share their knowledge and practice with others. As such, they acted as WoW experts and champions. Related to this was the support provided by the Moodle online platform which was a helpful resource to WoW Practitioners in their work.

Grass roots pathways were valuable in transmitting WoW thinking and practice. Multiple respondents noted that many individuals and communities were more receptive to positive mental health and wellbeing messages when they were shared by trusted local people. Local community organisations had trained local volunteers as WoW facilitators and they believed communication messages shared by them were more easily adopted when compared to receiving these messages from a large organisation or the government.

> They have the connections and are out there talking to people every day, that's how it spreads in small communities (depth focus group)

The community environments in which WoW messages and activities were often introduced was another important pathway for transmission. Participants highlighted the value of community markets and other fun local events as beneficial WoW introduction activity settings. These environments were considered helpful pathways because community members saw participation in activities as enjoyable and interesting. Participation in these initial activities often led to further engagement through follow up conversations, the provision of resources, or workshop attendance.

Finally, while QMHC was the WCB Project funder, they were also recognised as important cheerleaders and supporters of the WoW, and important to further dissemination. For example, their capacity to leverage engagement with the Queensland Department of Education and regional wellbeing hubs was viewed as pivotal in building pathways into these settings.

6.4 Conclusion: Transmission and ripple effects

The WoW has been widely disseminated across different sectors and settings, successfully being shared with diverse population groups. Most review participants were introduced to the WoW in their workplace (including schools), while others discovered the WoW through local and sector networks and systems they participated in.

The WoW was enthusiastically shared by those who attended workshops and activities, and this should be seen as a key model strength. It is likely that for every WoW participant attending an initial Implemental workshop, many others have had access to the positive mental health and wellbeing messages and practices shared in these workshops.

This sharing occurred through structured and planned transmission effects, and more informal and organic ripple effects. Furthermore, dissemination of the WoW was noted to occur both vertically (within a given workplace, system or setting), and horizontally (across distinct sectors, systems or settings).

Structured and planned transmission effects occurred horizontally; participants frequently reported transferring WoW learnings from the workplace back home. This included using the WoW to frame family meetings, and discussions with intimate partners. The WoW was also used with friendship groups to intentionally participate in health promoting activities.

Broader vertical transmission effects were noted organisationally. There was widespread dissemination in workplace settings, including between primary and secondary schools and across large workforce groups through structured training. The WoW was also embedded into school policies and curriculum, with activities used and shared with both teachers and students.

System and community wide transmission occurred both vertically and horizontally. There were frequent examples of services sharing WoW practice with their national executive groups, and sector departments (vertical transmission), and through horizontal transmission between government, community and education settings. Collaborative use of the WoW to plan and coordinate work across multiple agencies and sectors highlighted the transmission of WoW into community settings, where engagement in, and demand for, the WoW was strong.

While less structured and intentional, ripple effects were also an important mechanism to share WoW thinking and practice. This occurred at an individual level where students shared what they learnt at school with their parents, and people who discovered the WoW in their workplace shared it with friends and sporting teams. Teachers opportunistically shared WoW resources with parents to support them during the COVID-19 pandemic. Ripple effects at organisational and systems levels also occurred through staff role transitions and community based ‘word of mouth’ which produced strong demand for WoW activities in some local community settings.

Key pathways considered important to these transmission and ripple effects included education networks and systems where the WoW was widely discussed and shared, and regional wellbeing hubs which promoted the WoW and encouraged uptake in local communities. WoW practitioners and champions were

also identified as important conduits for WoW dissemination. Grassroots pathways were acknowledged too, with local and trusted community members being trained in the WoW and providing a trusted link into some isolated communities.

A key strength of the WoW, and the capacity building model underpinning it has been the motivation of participants to share it broadly, and often outside of the setting in which they were initially exposed to it. This has facilitated dissemination of the WoW into a wide variety of new settings and contexts, providing support to diverse population groups.

7 CONCLUSION

A total of 118 participants provided input to the WCB Project Review. Findings demonstrate the WoW framework and associated resources have effectively transmitted and embedded positive mental health and wellbeing thinking and practice into a wide range of sectors and settings, and to distinct population groups. The framework's flexible and adaptable nature has facilitated this.

Review participants believed awareness and engagement, and practice change related to positive mental health, have increased as a result of the project. Important changes in awareness and engagement, and practice, were identified at individual, organisational and community levels. All sectors and settings reported helpful changes, although the greatest changes were noted within the education sector. It should be noted that the practitioner survey sample largely came from the education sector. There is some qualitative evidence to suggest that WoW concepts and activities are having positive impacts on the mental health and wellbeing of participants.

There is strong evidence demonstrating that the WoW is being embedded and integrated into individual behaviours, organisational practices, and within specific sectors and community settings. Uptake of workshops and activities has been strong, particularly in the education and community health sectors. A range of structural factors were identified as important conditions to effectively implementing and embedding the WoW, including leadership in local settings. A wide range of concepts, resources and activities have been shared through participation in the project, and many of these have been adopted and adapted for specific settings or population groups. WoW practitioner support and resources have been important in facilitating implementation and integration of the WoW framework, however some barriers to implementation were also identified.

The capacity building model being used to improve health and wellbeing appears to be working as intended, with participants supporting the Theory of Change developed. Additional capacity building elements were also identified which may be valuable to highlight and build on. Participants suggested future capacity building focus areas which may further improve model roll out and success, especially at a systems level.

Structured transmission and organic ripple effects, allowing WoW concepts, activities and resources to filter into new settings, were identified at individual, organisational and broader systems and community levels. Key pathways included the education system and regional wellbeing hubs, along with key WoW practitioners and champions.

In summary, the WCB Project appears to have effectively engaged key sectors and settings, shared clear and accessible information and activities that can be easily used, and built motivation for the WoW framework to be more broadly adopted and embedded. This has occurred through strong resourcing and support from QMHC, and via transmission and ripple effects where participants share their WoW learnings with other individuals, organisations and the community.

ABBREVIATIONS

- HREC – Human Research Ethics Committee
- QMHC – Queensland Mental Health Commission
- TAFE – Technical and Further Education
- ToC – Theory of Change
- WoW – Wheel of Wellbeing
- WCB Project – Wellbeing Capacity Building Project