Parliamentary Committees

Inquiry into the opportunities to improve mental health outcomes for Queenslanders

Report No. 1, 57th Parliament
Mental Health Select Committee
June 2022

Mental Health Select Committee

Chair	Mr Joe Kelly MP, Member for Greenslopes
Deputy Chair	Mr Rob Molhoek MP, Member for Southport
Members	Ms Amanda Camm MP, Member for Whitsunday
	Mr Robbie Katter MP, Member for Traeger (until 4 March 2022)
	Ms Ali King MP, Member for Pumicestone
	Dr Amy MacMahon MP, Member for South Brisbane (from 31 March 2022)
	Mrs Melissa McMahon MP, Member for Macalister
	Mr Barry O'Rourke MP, Member for Rockhampton
	Dr Christian Rowan MP, Member for Moggill

Committee Secretariat

Telephone	+61 7 3553 6696
Fax	+61 7 3553 6699
Email	mshc@parliament.qld.gov.au
Technical Scrutiny Secretariat	+61 7 3553 6601
Committee webpage	www.parliament.qld.gov.au/mshc

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The committee would like to sincerely thank all of the community organisations and stakeholders that contributed to the committee's hearings and site visits throughout the inquiry, and expresses its appreciation for those who are supporting people experiencing mental ill-health or suicidality across Queensland.

All web address references are current at the time of publishing.

Contents

Abbreviations

AAPi	Australian Association of Psychologists
ABF	activity based funding
ACA	Australian Counselling Association
ACCHO	Aboriginal Community Controlled Health Organisation
ACE	Adverse Childhood Experience
ACMHN	Australian College of Mental Health Nurses
ACNP	Australian College of Nurse Practitioners
the Act	*Mental Health Act 2016*
ADF	Australian Drug Foundation
AIHW	Australian Institute of Health and Welfare
AOD	alcohol and other drugs
AMAQ	Australian Medical Association Queensland
APS	Australian Psychological Society
Bilateral Schedule	*The Bilateral Schedule on Mental Health and Suicide Prevention: Queensland* (between the Queensland and Australian Governments)
CALD	culturally and linguistically diverse
COA	Care Opinion Australia
COAG	Council of Australian Governments
Committee	Mental Health Select Committee
DBT	Dialectic Behavioural Therapy
DCYJMA	Department of Children, Youth Justice and Multicultural Affairs
DoE	Queensland Department of Education
DoH	Queensland Department of Health
ED(s)	emergency department(s)
EMDs	Emergency Medical Dispatchers
Every Life	*Every Life: The Queensland Suicide Prevention Plan 2019-2029: Phase One*

FTE	full-time equivalent
GP(s)	general practitioner(s)
HHS(s)	hospital and health service(s)
HITH	Hospital in the Home
IDD	intellectual and developmental disability
inquiry	Mental Health Select Committee's inquiry into the opportunities to improve mental health outcomes for Queenslanders
ISQ	Independent Schools Queensland
IUIH	Institute for Urban Indigenous Health
LGBTIQA+	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning or Asexual
Mater joint submission	Mater Intellectual Disability and Autism Service (MIDAS), Mater and the Queensland Centre for Intellectual and Developmental Disability (QCIDD), and the Mater Research Institute-University of Queensland provided a joint submission
MATES	MATES in Construction
MBS	Medicare Benefits Schedule
MH	mental health
MH CORE	Mental Health Co-Responders
MHLS	Mental Health Liaison Service
MHAOD	mental health alcohol and other drugs
MIDAS	Mater Intellectual Disability and Autism Service
MIFA	Mental Illness Fellowship Australia
National Agreement	*The National Agreement on Closing the Gap*
National Guidelines	*The National Lived Experience (Peer) Workforce Development Guidelines*
NMHSPF	*National Mental Health Service Planning Framework*
National Strategic Framework	*The National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing*
NHRA	National Health Reform Agenda

NDIS	National Disability Insurance Scheme
NGO(s)	non-government organisation(s)
OPG	Office of the Public Guardian
PBS	Pharmaceutical Benefits Scheme
PGA	Pharmacy Guild of Australia
PHN(s)	primary health network(s)
QAMH	Queensland Alliance for Mental Health
QAS	Queensland Ambulance Service
QCIDD	Queensland Centre for Intellectual and Developmental Disability
QCPIMH	Queensland Centre for Perinatal and Infant Mental Health
QFCC	Queensland Family and Child Commission
QFMHS	Queensland Forensic Mental Health Service
QMHC	Queensland Mental Health Commission
QNADA	Queensland Network of Alcohol and Other Drug Agencies Ltd
QNMU	Queensland Nurses and Midwives' Union
QPASTT	Queensland Program of Assistance to Survivors of Torture and Trauma
QPHN/Queensland PHNs	Queensland Primary Health Networks
QPS	Queensland Police Service
Queensland Lived Experience Framework	*Queensland Framework for the Development of the Mental Health Lived Experience*
Queensland PHNs/QPHNs	Queensland Primary Health Networks
QuIVAA	Queensland Injectors Voice for Advocacy and Action
RANZCP Queensland Branch	The Royal Australian and New Zealand College of Psychiatrists – Queensland Branch
RFDS	Royal Flying Doctor Service
RPBS	Repatriation Pharmaceutical Benefits Scheme

Shifting Minds	*Shifting Minds - Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023*
SPA	Suicide Prevention Australia
SUD	substance use disorder
Victoria DoH	Victoria Department of Health

Chair's foreword

I acknowledge all the people with lived experience of mental ill-health, suicidality and alcohol and other drugs issues, and thank those who participated in the inquiry for their significant contribution.

It would be rare to find someone in our community who has not been impacted by one or more of these issues. The impact on the individual can be enormous, frequently fatal, and the impacts on families and society cannot be underestimated.

There have been numerous inquiries into mental health reform at all levels of government. The committee was challenged by one witness not to add another report to the pile. This report has considered relevant past inquiry reports and examined more recent phenomena, such as the emerging role of people with lived experience, ongoing efforts by Aboriginal and Torres Strait Islander peoples to achieve justice, the introduction of the NDIS, the impact of COVID-19, changing treatment modalities and workforce pressures. The committee has taken all of this into consideration and, with the help of people with lived experience, health professionals, volunteers, community organisations, government departments and the business community, has produced a report that is aimed at improving mental health outcomes for people living in this large, diverse, and complex state. We hope it can be used by Queensland governments now and into the future to improve the lives of people living with mental ill-health, suicidality or alcohol and other drugs issues.

Aboriginal and Torres Strait Islander peoples consistently told the committee of the intergenerational trauma caused by colonisation, and subsequent government policies, and the significant impact on the mental health and wellbeing of their communities. Aboriginal and Torres Strait Islander peoples told the committee that efforts to achieve justice like the Uluru Statement from the Heart, Path to Treaty, and reconciliation programs are not tokenistic, but are welcomed as genuine attempts to heal the scar at the core of our society, which continues to have an enormous impact on their lives. Additionally, the delivery of health services through community controlled health organisations is an essential step towards the empowerment of Aboriginal and Torres Strait Islander communities. The committee saw this in action in Yarrabah, and we are thankful to the local community for welcoming and supporting the inquiry.

Much like physical diseases, mental health and alcohol and other drugs issues can be thought of as occurring along a continuum where social determinants, prevention, diagnosis, early intervention, crisis care, acute care, rehabilitation and ongoing care all play a role.

This report has considered all aspects of the continuum and identified significant opportunities to improve mental health and wellbeing in Queensland including:

- planning and governance of mental healthcare
- developing a mental health and wellbeing strategy
- reducing stigma and encouraging help-seeking
- developing workplace and small business prevention strategies
- providing housing and employment support
- implementing more person-centred case management and support
- expanding services across the continuum, including in perinatal and infant mental health, child and youth mental health, adult and older persons mental health
- increasing specialised services, including acute and rehabilitation services, early psychosis and eating disorder services, and suicide prevention services
- reforming the primary healthcare system
- addressing the missing middle, particularly utilising community organisations

- ensuring the NDIS empowers individuals towards independence
- improving and expanding crisis and emergency care systems
- increasing services for people in the criminal justice system
- targeted consideration for at-risk populations including but not limited to Aboriginal and Torres Strait Islander peoples, culturally and linguistically diverse communities, people with intellectual and development disabilities, and the LGBTIQA+ communities
- developing a state-wide trauma strategy to support people who have experienced adverse childhood events, domestic and family violence, physical or sexual assault, and work-related or other forms of trauma.

It is simple to summarise the findings of the committee but implementation will take courage, commitment, coordination, funding and ongoing efforts by governments and our community.

If unlimited financial resources existed to deliver services, our state would still face a major challenge delivering needed services due to workforce pressures. The committee closely examined this issue and determined that it requires urgent attention and cooperation from governments at every level. COVID-19 has had a significant impact on the health workforce. I would like to acknowledge the more than 118,000 health workers globally who have died as a result of caring for people with COVID-19. There are many opportunities to address workforce issues; one key area for consideration is expanding the lived experience (peer) workforce. I also want to acknowledge the dedicated staff who work with people experiencing mental ill-health, suicidality or alcohol and other drugs issues. They are truly dedicated and are already doing fantastic work. They told the committee they are capable of even greater work with the right support.

The Queensland Mental Health Commissioner often stated that across the spectrum of our system, healthcare practitioners are working hard to help many people, and pockets of excellence exist. We are starting from a strong base, but there is much to do. It is hoped that this report provides guidance, so we can move from pockets of excellence to a system of excellence.

The committee started and finished the inquiry listening to the voices of people with lived experience. I particularly want to thank Stepping Stone Clubhouse for hosting our first public hearing. I want to acknowledge the Member for Macalister, Mrs Melissa McMahon, not only for sharing her own experiences, but for making a significant contribution to the report, the Parliament of Queensland and her community while experiencing mental ill-health. The committee took every opportunity to listen to people with lived experience, extending the scheduled hearing times and during site visits throughout Queensland. People told us stories of stigmatisation, poor service, trauma, estrangement from families and loved ones, and of not being listened to or believed. However, people also told us of hope and their views on ways to fix things, do things better, and empower people. It is hoped that this report demonstrates that we have not only listened to those people, but made recommendations that will improve the lives of all Queenslanders.

Finally, I would like to thank and acknowledge the Premier and the Government for initiating this inquiry. I would like to thank the people and organisations that made submissions. I also wish to thank the committee members who have worked together in a collegial and diligent manner. Particular thanks to the secretariat staff who have gone above and beyond to assist in the creation of a very useful and important report. Lastly, thanks to the many people with lived experience who had the faith to engage with this inquiry. I commend this report to the House.

Joe Kelly MP

Chair

Recommendations

The committee recommends the Queensland Government:

a) increases funding and expenditure for mental health and alcohol and other drugs services in Queensland.
b) creates a dedicated funding stream for mental health and alcohol and other drug services and explores all options to create it.
c) investigates and implements accountability mechanisms to ensure service providers are delivering agreed mental health and alcohol and other drugs services, including reporting expenditure in Hospital and Health Services annual reports.

The committee recommends the Queensland Government:

a) applies 5-year funding cycles to state-funded mental health and alcohol and other drug services.
b) sets measurable goals for state-funded programs to assist in service evaluation for funding purposes.

The committee recommends the Queensland Government investigates and implements strategies to better involve families, carers and support persons in the mental health care and treatment of individuals.

The committee recommends the Queensland Government evaluates Care Opinion Australia's consumer feedback model for implementation in Queensland, or other alternatives that incorporate independent consumer feedback.

The committee recommends the Queensland Government:

a) develops and implements a public health campaign to reduce stigma associated with mental ill-health, alcohol and other drugs issues and eating disorders, which also encourages help-seeking and help-offering behaviours.
b) in conjunction with the development of a public mental health campaign, develops mental health awareness training tools and programs for use in the public, private, not-for-profit and education sectors.
c) encourages the uptake of Mental Health First Aid training.

The committee recommends the Queensland Government develops a whole-of-government trauma strategy to be implemented by the Queensland Government, and that the strategy:

a) considers multidisciplinary trauma research and implements best practice strategies for responding to people that have experienced trauma, including but not limited to physical and sexual abuse, domestic and family violence and adverse childhood experiences.
b) considers how trauma-informed practice can be embedded in service provision in human services areas, including health, housing, education, corrective services and child safety.

d) considering the mental health and alcohol and other drugs services required across an individual's lifespan, including but not limited to, early psychosis services to support children and young people, as well as mental healthcare services for individuals within perinatal and infant, adult, and older persons population groups.
e) prioritising consideration of strategies to address the 'missing middle' services gap.
f) clearly identifying which agency is funding which aspect of the plan.
g) in relation to Aboriginal and Torres Strait Islander discrete communities, establishing the community controlled health organisation as the lead agency for service delivery, workforce planning and funding; and in other locations with Aboriginal and Torres Strait Islander populations, establishing a sub-regional plan led by the community controlled health organisation.

The committee recommends that the Queensland Government:

a) explores ways to improve opportunities for:
   i. clinical supervision for mental health and alcohol and other drugs staff
   ii. meaningful training and development opportunities that will upskill staff in providing mental health and alcohol and other drugs related care.
b) identifies opportunities to remove financial and other barriers to practitioners providing clinical supervision and incentivise clinical supervision accreditation to support workforce development.

The committee recommends the Queensland Government re-establishes the Mental Health Workforce Planning and Development Branch within the Department of Health and that the branch engages with the secondary and tertiary education sectors in developing the mental and alcohol and other drugs workforce.

The committee recommends that the Queensland Government:

a) reviews employee entitlements for clinical and non-clinical mental health and alcohol and other drugs roles to incentivise work in regional, rural and remote communities, including housing entitlements.
b) investigates and implements additional strategies to attract and retain skilled mental health and alcohol and other drugs practitioners to regional, rural and remote parts of Queensland, and considers safe working conditions for people working in these locations.
c) that formal certification of advanced credentialed practice for Mental Health and/or Addiction Medicine for Rural Generalists be formally recognised by Queensland Health.

The committee recommends the Queensland Government funds scholarships for nurses, midwives, medical officers and allied health professionals, such as occupational therapists and counsellors, to pursue mental health and alcohol and other drugs qualifications.

The committee recommends the Queensland Government reviews how the health practitioner structure operates within Queensland Health, including whether there are sufficient clinical roles across the 8-level structure to attract and retain clinical staff.

1 Introduction

1.1 Role of the committee and referral of inquiry

On 2 December 2021, the Legislative Assembly agreed to a motion that established the Mental Health Select Committee (committee) as a select committee to undertake an inquiry and report on the opportunities to improve mental health outcomes for Queenslanders (the inquiry).

The committee's terms of reference for the inquiry are as follows:

1. A select committee, to be known as the Mental Health Select Committee, be established to undertake an inquiry and report on the opportunities to improve mental health outcomes for Queenslanders.

   In undertaking the inquiry, the committee consider:

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

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

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

      a. across the care continuum from prevention, crisis response, harm reduction, treatment and recovery;

      b. across sectors, including Commonwealth funded primary care and private specialist services, state funded specialist mental health services, non-government services and services funded by the NDIS [National Disability Insurance Scheme];

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

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

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

   (g) service safety and quality, workforce improvement and digital capability;

   (h) mental health funding models in Australia; and

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

2. The committee have power to call for persons, documents and other items;
3. The committee report to the Legislative Assembly by 31 May 2022;
4. The committee consist of eight members of the Legislative Assembly: four members (including the Chairperson) appointed by the Leader of the House and four members appointed by the Leader of the Opposition;
5. That, notwithstanding anything contained in standing orders, the appointment of members to the committee shall be by the Leader of the House and the Leader of the Opposition in writing to the Clerk with their appointments by 10 December 2021. The Clerk to table the letters of appointment.
6. If the Leader of the Opposition does not appoint all required members as outlined in (4) by the date in (5), the select committee is still a fully constituted committee with the members appointed by the Leader of the House.[1]

[1] Queensland Parliament, Record of Proceedings, 2 December 2022, pp 4026-4027.

On 10 May 2022, the Legislative Assembly resolved to extend the reporting date for the inquiry to 6 June 2022.[2]

1.2 Inquiry process

On 15 December 2021, the committee invited stakeholders and subscribers to make written submissions to the committee. One hundred and sixty-four submissions were received (a list of submitters is at **Appendix A**).

The committee received public briefings about the inquiry on 20 January 2022, 11 and 17 February 2022, and 12 April 2022 from officials from:

- Queensland Health
- Queensland Mental Health Commission (QMHC)
- Queensland Ambulance Service (QAS)
- Department of Children, Youth Justice and Multicultural Affairs (DCYJMA)
- Department of Education (DoE)
- Queensland Treasury
- Queensland Police Service (QPS).

A list of departmental officers who attended the briefings is at **Appendix B**.

The committee received a written briefing from Queensland Health in response to matters raised in submissions. The committee also received written advice in response to the terms of reference from:

- QMHC
- Department of Communities, Housing and Digital Economy
- Department of Environment and Science
- Office of Industrial Relations, Department of Education
- Queensland Health.

The committee held 4 private hearings[3] and 15 public hearings in Brisbane and across Queensland to hear from submitters, stakeholder groups and members of the public. The committee heard evidence from 243 witnesses (a list of witnesses is at **Appendix C**).

Public hearings were held in:

- Coorparoo – 27 January 2022
- Brisbane – 11, 16, 17 and 18 February; 10 and 11 March; 12, 13, 28 and 29 April 2022
- Bundaberg – 7 March 2022
- Hervey Bay – 8 March 2022
- Gold Coast – 18 March 2022
- Kingaroy – 20 April 2022.

[2] Queensland Parliament, Record of Proceedings, 10 May 2022, pp 933.

[3] The committee resolved to publish transcripts of two private hearings held on 11 February 2022 and 29 April 2022.

The committee also conducted 11 site visits across Queensland:

- Stepping Stone Clubhouse, Coorparoo – 27 January 2022
- Wide Bay Hospital and Health Service (HHS), Mental Health and Specialised Services, and Hervey Bay Hospital, Hervey Bay – 8 March 2022
- Jacaranda Place, Children's Health Queensland HHS, Chermside – 9 March 2022
- MATES in Construction, Spring Hill – 9 March
- Lavender Mother and Baby Unit, Gold Coast University Hospital, Southport – 18 March 2022
- Goldbridge Rehabilitation Services, Southport – 18 March 2022
- Yarrabah Aboriginal Shire Council, Yarrabah – 21 March 2022
- Youth Empowered Towards Independence, Cairns – 22 March 2022
- Australian Red Cross, Cairns – 22 March 2022
- Cairns and Hinterland HHS, Cairns – 22 March 2022.

The submissions, correspondence from departments, transcripts of the public briefings and hearings, tabled papers and responses to questions taken on notice at public briefings and hearings are available on the committee's webpage.

The committee in Yarrabah meeting with the Yarrabah Aboriginal Shire Council Mayor, Chief Executive Officer and community representatives on 21 March 2022.

1.3 A note on content

The committee acknowledges that some of the evidence and analysis in this report may contain information that could be distressing. If the information causes you distress, the committee encourages you to seek support. A number of support organisations who can assist you are listed on the committee's webpage.

2 Policy and legislative context of inquiry

The committee acknowledges the breadth of work that has already been undertaken to reform mental health and alcohol and other drugs (AOD) service systems nationally, and in other jurisdictions. The committee has been tasked with considering national and state policies and programs, and the findings of recent inquiries, to identify the opportunities to improve mental health outcomes for Queenslanders.

This chapter sets out the policy and legislative context relevant to Queensland's mental health and AOD service system.

2.1 Definition of mental illness

The Australian Institute of Health and Welfare (AIHW) states that mental health is a key component of overall health and wellbeing. According to the Australian Government Department of Health, good mental health enables you to cope with the normal stresses of life, be productive both at work and in your private life, relate well to other people and contribute to your community.[4]

A person's mental health is affected by multiple socioeconomic factors, including access to services, living conditions and employment status. Mental health affects not only individuals but their families and carers.[5]

Mental illness, or mental ill-health, can be defined as a health problem that affects people's thoughts, mood, behaviour or the way they perceive the world around them. Mental ill-health is associated with distress and may affect an individual's ability to function at work, in relationships or in everyday tasks.[6]

While most people will experience good mental health and wellbeing most of the time, many Queenslanders will experience difficulties with their mental health at some point in their lives. For some, these challenges may be temporary; for others, they may persist over a long period. However, people living with mental ill-health can and do experience good mental health.[7]

2.2 Key policy inquiries

The committee's terms of reference require it to consider relevant national and state policies, reports and recent inquiries including, the Productivity Commission's inquiry into the economic impacts of mental ill-health.

This section sets out key policy inquiries and outlines relevant Australian and Queensland Government policies and legislation.

2.2.1 Productivity Commission inquiry into the economic impacts of mental ill-health

On 23 November 2018, the Australian Government announced the terms of reference for the Productivity Commission's inquiry into mental health.[8] The inquiry examined the effect of mental

4 Australia Government, Department of Health, *About mental health,* https://www.health.gov.au/health-topics/mental-health-and-suicide-prevention/about-mental-health.

5 Australian Institute of Health and Welfare, *Mental Health Services in Australia*, web report, 1 February 2022.

6 Health Direct, *Mental Illness*, https://www.healthdirect.gov.au/mental-illness; American Psychiatric Association, *About Mental Health,* https://www.psychiatry.org/patients-families/what-is-mental-illness.

7 Queensland Health, *The health of Queenslanders 2020: report of the Chief Health Officer Queensland*, November 2020, p 56; Queensland Mental Health Commission, *Shifting Minds – Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023*, p 11.

8 Hon Josh Frydenberg MP and Hon Greg Hunt MP, *Productivity Commission inquiry into mental health terms of reference*, joint media release, 23 November 2018.

health on people's ability to participate and prosper in the community and workplace, and the effects it has more generally on our economy and productivity.[9]

The inquiry looked at how governments across Australia, employers, professional and community groups in healthcare, education, employment, social services, housing and justice can contribute to improving mental health for people of all ages and cultural backgrounds.[10]

The Productivity Commission was asked to:

- examine the effect of supporting mental health on economic and social participation, productivity and the Australian economy
- examine how sectors beyond health, including education, employment, social services, housing and justice, can contribute to improving mental health and economic participation and productivity
- examine the effectiveness of current programs and initiatives across all jurisdictions to improve mental health, suicide prevention and participation, including by governments, employers and professional groups
- assess whether the current investment in mental health is delivering value for money and the best outcomes for individuals, their families, society and the economy
- draw on domestic and international policies and experience where appropriate
- develop a framework to measure and report the outcomes of mental health policies and investment on participation, productivity and economic growth over the long term.[11]

The Productivity Commission provided its report to the Australian Government on 30 June 2020, and it was publicly released on 16 November 2020.[12]

The Productivity Commission found that Australia's current mental health system is not comprehensive and that reform of the mental health system would produce large benefits in quality of life for people with mental ill-health valued at up to $18 billion annually, with an additional annual benefit of $1.3 billion due to increased economic participation.[13]

Priority reform areas included:

- providing prevention and early help for people
- improving people's experiences with mental healthcare
- improving people's experiences with services beyond the health system
- equipping workplaces to support mental health
- instilling incentives and accountability for improved outcomes.[14]

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9 Australian Government, Productivity Commission, 'Mental Health', https://www.pc.gov.au/inquiries/completed/mental-health#report.

10 Australian Government, Productivity Commission, 'Mental Health', https://www.pc.gov.au/inquiries/completed/mental-health#report.

11 Australian Government, Productivity Commission, 'Mental Health, Terms of reference', https://www.pc.gov.au/inquiries/completed/mental-health/terms-of-reference.

12 Australian Government, Productivity Commission, 'Mental Health', https://www.pc.gov.au/inquiries/completed/mental-health#report.

13 Australian Institute of Health and Welfare, *Mental health services in Australia*, 'Overview of mental health services in Australia', 1 February 2022.

14 Productivity Commission, *Mental health inquiry report,* No. 95, 2020, vol 1, p 3.

2.2.2 Royal Commission into Victoria's Mental Health System

In February 2019, on advice from the Victorian Government, the Governor of the State of Victoria established the Royal Commission into Victoria's Mental Health System. This reportedly signalled that the state's mental health system was failing to support those who needed it.[15]

The Royal Commission was asked to make recommendations on the following:

- how to most effectively prevent mental illness and suicide, and support people to recover from mental illness, early in life, early in illness and early in episode, through Victoria's mental health system, and in close partnership with other services
- how to deliver the best mental health outcomes and improve access to and the navigation of Victoria's mental health system for people of all ages
- how to best support the needs of family members and carers of people living with mental illness
- how to improve mental health outcomes, taking into account best practice and person-centred treatment and care models, for those in the Victorian community, especially those at greater risk of experiencing poor mental health
- how to best support those in the Victorian community who are living with both mental illness and problematic alcohol and drug use, including through evidence-based harm minimisation approaches
- any other matters necessary to satisfactorily resolve the matters set out above.[16]

The Royal Commission advised that:

> Despite the goodwill and hard work of many people, Victoria's mental health system has deteriorated for a multitude of reasons and over the course of many years. In November 2019, the Commission's interim report concluded that the system had catastrophically failed to live up to expectations and was underprepared for current and future challenges. Good mental health and wellbeing have been a low priority of governments at all levels and the community.[17]

The Royal Commission released its final report on 3 February 2021, including a reform agenda to redesign Victoria's mental health and wellbeing system. The Royal Commission determined the present system is not designed to support the diverse needs of people living with mental illness or psychological distress and noted the pressure on the system resulting from the COVID-19 pandemic and 2019–20 severe bushfire season.[18]

Some of the key themes the Royal Commission identified include:

- demand has overtaken capacity and services are poorly integrated
- community-based services are undersupplied and there is a 'missing middle'[19]

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15 Royal Commission into Victoria's Mental Health System, *Summary and recommendations*, Victorian Government Printer, February 2021, p 3.

16 Royal Commission into Victoria's Mental Health System, 'Royal Commission letters patent', http://rcvmhs.archive.royalcommission.vic.gov.au/key-documents.html.

17 Royal Commission into Victoria's Mental Health System, *Summary and recommendations*, Victorian Government Printer, February 2021, p 3.

18 Royal Commission into Victoria's Mental Health System, *Final Report Vols 1-5*, 2021.

19 A large and growing population of people have needs that are too 'complex' to be supported through primary care, but not 'severe' enough to meet the strict criteria for entry into specialist mental health services.

- there is a patchwork of services that do not reflect local needs
- the system is driven by crises and emergency departments (EDs) are used as entry points
- the perspectives and experiences of people with lived experience of mental illness or psychological distress are overlooked
- some population groups face further barriers.[20]

The Royal Commission's recommendations and proposed reform agenda were based heavily on engagement with people who have lived experience. The Victorian Government accepted all recommendations from the report and has commenced their implementation.[21]

2.2.3 Royal Commission into Defence and Veteran Suicide

The committee notes that on 8 July 2021, a Royal Commission into Defence and Veteran Suicide (the Royal Commission) was established. The inquiry's terms of reference are as follows:

a) systemic issues and any common themes among defence and veteran deaths by suicide, or defence members and veterans who have other lived experience of suicide behaviour or risk factors (including attempted or contemplated suicide, feelings of suicide or poor mental health outcomes);

b) a systemic analysis of the contributing risk factors relevant to defence and veteran death by suicide, including the possible contribution of pre-service, service (including training and deployments), transition, separation and post-service issues, such as the following:

   i. the manner or time in which the defence member or veteran was recruited to the [the Australian Defence Force (the ADF)];

   ii. the relevance, if any, of the particular branch, service or posting history, or the rank of the defence member or veteran;

   iii. the manner or time in which the defence member or veteran transitioned from the ADF or transitioned between service categories;

   iv. the availability, accessibility, timeliness and quality of health, wellbeing and support services (including mental health support services) to the defence member or veteran, and the effectiveness of such services;

   v. the manner and extent to which information about the defence member or veteran is held by and shared within and between different government entities;

   vi. the reporting and recording of information, relevant to the mental and physical health of defence members and veterans, at enlistment and during and after service;

c) the impact of culture within the ADF, the Department of Defence and the Department of Veterans' Affairs on defence members' and veterans' physical and mental wellbeing;

d) the role of non-government organisations, including ex-service organisations, in providing relevant services and support for defence members, veterans, their families and others;

e) protective and rehabilitative factors for defence members and veterans who have lived experience of suicide behaviour or risk factors;

[20] Royal Commission into Victoria's Mental Health System, *Summary and recommendations*, Victorian Government Printer, February 2021, pp 8-13.

[21] Royal Commission into Victoria's Mental Health System, *Final Report Vols 1-5*, 2021.

f) any systemic issues in the current availability and effectiveness of support services for, and in the engagement with, families and others:

   i. affected by a defence and veteran death by suicide; or

   ii. who have supported a defence member or veteran with lived experience of suicide behaviour or risk factors;

g) any systemic issues in the nature of defence members' and veterans' engagement with the Department of Defence, the Department of Veterans' Affairs or other Commonwealth, State or Territory government entities (including those acting on behalf of those entities) about support services, claims or entitlements relevant to defence and veteran deaths by suicide or relevant to defence members and veterans who have other lived experience of suicide behaviour or risk factors, including any systemic issues in engaging with multiple government entities;

h) the legislative and policy frameworks, administered by the Department of Defence, the Department of Veterans' Affairs and other Commonwealth, State or Territory government entities, relating to the support services, claims and entitlements referred to in paragraph (g);

i) any systemic risk factors contributing to defence and veteran death by suicide, including the following:

   i. defence members' and veterans' social or family contexts;

   ii. housing or employment issues for defence members and veterans;

   iii. defence members' and veterans' economic and financial circumstances;

j) any matter reasonably incidental to a matter referred to in paragraphs (a) to (i) or that [the Commissioners] believe is reasonably relevant to [their] inquiry.[22]

Committee comment

Although the committee considers the issue of veteran mental health and suicide to be of significant concern, the committee has not made any recommendations in this report due to the significant undertaking of the Royal Commission in its inquiry.

The committee notes the Royal Commission is due to produce an interim report by 11 August 2022 and awaits the commission's comprehensive findings about the systemic issues contributing to defence and veteran deaths by suicide or defence members and veterans who have other lived experience of suicide behaviour or risk factors.[23]

2.2.4 Queensland Parliament inquiries into related matters

2.2.4.1 Health and Environment Committee: Inquiry into the provision of primary, allied and private healthcare, aged care and NDIS care services and its impact on the Queensland public health system

The committee notes and supports the important work undertaken by the Queensland Parliament's Health and Environment Committee in its *Inquiry into the provision of primary, allied and private healthcare, aged care and NDIS care services and its impact on the Queensland public health system*.

[22] Royal Commission into Defence and Veteran Suicide, 'Terms of reference', https://defenceveteransuicide.royalcommission.gov.au/about/terms-reference.

[23] Royal Commission into Defence and Veteran Suicide, 'Terms of reference', https://defenceveteransuicide.royalcommission.gov.au/about/terms-reference.

The Health and Environment Committee made 40 recommendations in its report tabled on 8 April 2022.[24] The committee heard similar evidence during this inquiry relating to healthcare workforce pressures.

2.2.4.2 Community Support and Services Committee: Inquiry into social isolation and loneliness in Queensland

The committee also notes the important work undertaken by the Queensland Parliament's Community Support and Services Committee in its *Inquiry into social isolation and loneliness in Queensland*. The Community Support and Services Committee made 14 recommendations in its report tabled on 6 December 2021.[25]

Committee comment

The committee supports the findings of the Community Support and Services Committee's *Inquiry into social isolation and loneliness in Queensland* and endorses the implementation of the committee's 14 recommendations.

2.3 Key Australian Government policies

2.3.1 National Mental Health and Suicide Prevention Plan

Released on 12 May 2021, the *National Mental Health and Suicide Prevention Plan* is informed by the lived experiences of Australians and the advice and recommendations of the Productivity Commission and National Suicide Prevention Adviser.[26]

In the 2021-22 Federal Budget, the Australian Government announced a $2.3 billion investment over 4 years to the *National Mental Health and Suicide Prevention Plan*. The plan includes 5 pillars to this investment which address:

- prevention and early intervention
- suicide prevention
- treatment
- supporting the vulnerable
- workforce and governance.[27]

2.3.2 National Mental Health Service Planning Framework

The *National Mental Health Service Planning Framework* is an evidence-based framework, designed to support coordinated planning across Australia's mental health system. It helps providers of mental health services, such as Primary Health Networks (PHNs), local hospitals, state and territory

[24] Health and Environment Committee, *Report No. 18, 57th Parliament, Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system.*

[25] Community Support and Services Committee, *Report No. 14, 57th Parliament, Inquiry into social isolation and loneliness in Queensland.*

[26] Australian Government, Department of the Prime Minister and Cabinet, 'National Mental Health and Suicide Prevention Plan announced', 12 May 2021.

[27] Australian Institute of Health and Welfare, *Mental health services in Australia*, 'Overview of mental health services in Australia', 1 February 2022.

governments and the Australian Government, identify the kind of services that are required, and how many people require those services.[28]

2.3.3 National Lived Experience (Peer) Workforce Development Guidelines

The National Mental Health Commission led the development of the *National Lived Experience (Peer) Workforce Development Guidelines* (National Guidelines) in 2021 as a key reform initiative of the Fifth *National Mental Health and Suicide Prevention Plan*. [29]

The aim of the National Guidelines is to build a mental health lived experience workforce, with such a workforce being described as a vital component of quality, recovery-focused mental health services.[30] The National Guidelines describe lived experience workers as follows:

> Lived Experience workers draw on their life-changing experiences of mental or emotional distress, service use, and recovery/healing, and their experiences, or the impact of walking beside and supporting someone through these experiences, to build relationships based on collective understanding of shared experiences, self-determination, empowerment, and hope.
>
> …
>
> The Lived Experience workforce is made up of people who are employed in paid positions that require Lived Experience as an essential employment criterion, regardless of position type or setting.[31]

The National Guidelines identify five priorities for the mental health service system as a roadmap for leaders across diverse settings to establish policies and practices that support sustainable and effective workforce growth:

- develop understanding as a foundation for workforce development
- support a thriving lived experience workforce
- plan for workforce growth
- integrate lived experience work with community care
- support development with a national lived experience strategy.[32]

As well as providing an overview of the professional principles, values and roles of the lived experience workforce, the National Guidelines also provide detailed steps for employers to plan, engage and maintain a lived experience workforce.[33]

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28 Australian Government, Australian Institute of Health and Welfare, *National Mental Health Service Planning Framework,* https://www.aihw.gov.au/nmhspf/overview.

29 Australian Government, National Mental Health Commission, *Lived Experience (Peer) Workforce Development Guidelines*, p 4.

30 Australian Government, National Mental Health Commission, *Lived Experience (Peer) Workforce Development Guidelines*, p 2.

31 Australian Government, National Mental Health Commission, *Lived Experience (Peer) Workforce Development Guidelines*, p 4.

32 Australian Government, National Mental Health Commission, *Lived Experience (Peer) Workforce Development Guidelines*, p 7.

33 Australian Government, National Mental Health Commission, *Lived Experience (Peer) Workforce Development Guidelines*, p 4.

2.3.4 National Mental Health Workforce Strategy

The aim of the *National Mental Health Workforce Strategy 2011* is to develop and support a well-led, high performing and sustainable mental health workforce delivering quality recovery-focused mental health services.[34]

The strategy defines the mental health workforce as including:

> Mental health nurses, psychiatrists, general registered nurses, enrolled nurses, general and other medical practitioners, occupational therapists, social workers, psychologists, Aboriginal mental health workers, Aboriginal health workers, mental health workers, consumer workers and carer workers.[35]

The National Mental Health Workforce Strategy Taskforce is currently developing a new 10-year National Mental Health Workforce Strategy that will supersede the current strategy.[36]

A draft strategy was made available for public consultation between 12 August 2021 and 30 September 2021, and is currently being finalised.[37]

2.3.5 National Agreement on Closing the Gap

The National Agreement on Closing the Gap (National Agreement) is an agreement between the Coalition of Aboriginal and Torres Strait Islander Peak Organisations and all Australian governments, which took effect in July 2020. The objective of the National Agreement is to overcome the entrenched inequality faced by Aboriginal and Torres Strait Islander peoples so their life outcomes are equal to all Australians.[38]

The parties to the National Agreement agreed on 17 socio-economic targets. Target 14 is 'significant and sustained reduction in the suicide of Aboriginal and Torres Strait islander People towards zero'. The National Agreement identifies the indicators that can be used to provide a greater understanding of the issue:

- non-fatal hospitalisations for intentional self-harm
- intentional self-harm mortality rate (suicide)
- hospitalisations for mental health-related disorders
- proportion of Aboriginal and Torres Strait Islander peoples who report experiences of psychological distress
- proportion of people who report experiences of one of more barriers to accessing health services
- mental health-related disorders and mortality rates
- proportion of people who report having experienced racism in the previous 12 months.[39]

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34 Australian Government, Mental Health Workforce Advisory Committee, *National Mental Health Workforce Strategy 2011*, p 1.

35 Australian Government, Mental Health Workforce Advisory Committee, *National Mental Health Workforce Strategy 2011*, p 1.

36 Australian Government, Mental Health Workforce Advisory Committee, *National Mental Health Workforce Strategy 2011*, p 1.

37 Australian Government, Department of Health, 'National Mental Health Workforce Strategy Taskforce', https://www.health.gov.au/committees-and-groups/national-mental-health-workforce-strategy-taskforce.

38 Australian Government, Closing the Gap in Partnership, *National Agreement on Closing the Gap*, p 38.

39 Australian Government, Closing the Gap in Partnership, *National Agreement on Closing the Gap*, p 33.

The National Agreement also identified areas in which further data development is required to fully understand and achieve positive outcomes for Aboriginal and Torres Strait Islander peoples:

- mental health related Medicare services by general practitioners (GPs), psychologists and psychiatrists
- specialised mental healthcare services
- barriers to accessing mental health services
- improve the quality of Aboriginal and Torres Strait Islander identification in deaths data to support reporting of mental health-related mortality data, including self-harm mortality data for all states and territories, and at regional/community levels
- main factors leading to suicide by Aboriginal and Torres Strait Islander peoples
- alternative measure of psychological distress (preferably non-survey based)
- mental and behavioural mortality data including self-harm mortality data for all states and territories, and at regional/community levels
- prevalence of racist attitudes against Aboriginal and Torres Strait Islander peoples held by the Australian community
- rate of Aboriginal and Torres Strait Islander peoples who feel a strong connection to culture and community
- measures of suicide ideation, particularly among youth.[40]

2.3.6 National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing

The *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing* (National Strategic Framework) is intended to guide and inform Aboriginal and Torres Strait Islander mental health and wellbeing reforms.[41]

The National Strategic Framework aims to respond to the high incidence of social and emotional wellbeing problems and mental ill-health experienced by Aboriginal and Torres Strait Islander peoples. Further, it aims to contribute to achieve the Closing the Gap target for Aboriginal and Torres Strait Islander and non-indigenous life expectancy equality by 2031.[42]

The National Strategic Framework identifies 5 action areas:

- strengthen the foundations
- promote wellness
- build capacity and resilience in people and groups at risk
- provide care for people who are mildly or moderately ill
- care for people living with severe mental illness.[43]

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40 Australian Government, Closing the Gap in Partnership, *National Agreement on Closing the Gap*, p 33.

41 Australian Government, National Indigenous Australians Agency, *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing*, p 2.

42 Australian Government, National Indigenous Australians Agency, *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing*, p 2.

43 Australian Government, National Indigenous Australians Agency, *National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing*, p 16.

2.3.7 Bilateral Schedule on Mental Health and Suicide Prevention: Queensland

The Bilateral Schedule on Mental Health and Suicide Prevention: Queensland (Bilateral Schedule), signed in March 2022, is an agreement between the Australia and Queensland Governments. While the shared nature of responsibility for healthcare between the Australian Government and states is set out in the *National Health Reform Agreement 2020-2025*, the Bilateral Schedule sets out the specific responsibilities for Australia and Queensland in relation to establishing, funding and maintaining specific mental health services.[44]

As well as the implementation and funding of mental health services, the Bilateral Schedule also states that the Australian and Queensland Governments will work collaboratively to implement systemic reforms that:

- address gaps in the mental health and suicide prevention system
- improve mental health outcomes for all people in Queensland
- prevent and reduce suicidal behaviour
- deliver a mental health and suicide prevention system that is comprehensive, coordinated, consumer-focused and compassionate.[45]

The Bilateral Schedule outlines financial contributions of $150.85 million by the Australian Government and $109.55 million by the Queensland Government, over a 5-year period.[46]

2.4 Key Queensland bodies, policies and legislation

2.4.1 *Mental Health Act 2016*

The *Mental Health Act 2016* (the Act) establishes the regulatory framework for the involuntary treatment, care and protection of people who have a mental illness and who do not have capacity to consent to be treated.[47]

The main objects of the Act are to:

- improve and maintain the health and wellbeing of persons who have a mental illness who do not have the capacity to consent to be treated
- enable persons to be diverted from the criminal justice system if found to have been of unsound mind at the time of committing an unlawful act or to be unfit for trial
- protect the community if persons diverted from the criminal justice system may be at risk of harming others.[48]

The Chief Psychiatrist is the statutory officer who is responsible for facilitating the proper and efficient administration of the Act. The Chief Psychiatrist does not act under the direction of the Minister when exercising their functions.[49]

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44 Australian Government, Department of Health, *National Health Reform Agreement 2020-2025*; Queensland Health, tabled paper, public hearing, Brisbane, 28 April 2022, Bilateral Schedule of Mental Health and Suicide Prevention: Queensland.

45 Queensland Health, tabled paper, public hearing, Brisbane, 28 April 2022, Bilateral Schedule of Mental Health and Suicide Prevention: Queensland, p 6.

46 Queensland Health, tabled paper, public hearing, Brisbane, 28 April 2022, Bilateral Schedule of Mental Health and Suicide Prevention: Queensland, p 6.

47 Submission 150, p 53.

48 *Mental Health Act 2016* s 3.

49 Queensland Health, briefing paper, 1 February 2022, p 12.

In accordance with section 26 of the Act, the Chief Psychiatrist makes policies and practice guidelines under the Act. A suite of policies have been developed under this section, including:

- patient rights and support
- examination and assessment
- treatment and care
- courts, forensic patients and people in custody
- seclusion and restraint
- transport, movement and patient absence
- Mental Health Review Tribunal
- administration of the Act.[50]

The Act and associated policies and guidelines have been assessed as compatible with the *Human Rights Act 2019*. The Act focuses on individual rights, and any limitation on rights (eg involuntary treatment) is subject to strict legislative criteria and requirements, intended to ensure that the limitation is necessary and the least restrictive in the specific circumstance.

2.4.2 Queensland Mental Health Commission

The role of the QMHC is to drive reform of the mental health and AOD systems in Queensland by identifying issues and priorities, advising on reform options, supporting the efforts of others to implement change and checking progress.[51] The functions and powers of the QMHC are contained in the *Queensland Mental Health Commission Act 2013*.

The main functions of the commission are as follows:

- to prepare a whole-of-government strategic plan;
- to monitor and report to the Minister on implementation of the whole-of-government strategic plan;
- to review the whole-of-government strategic plan;
- to review, evaluate, report and advise on—
    - the mental health and substance misuse system; and
    - other issues affecting relevant persons; and
    - issues affecting community mental health and substance misuse;
- to promote and facilitate the sharing of knowledge and ideas about mental health and substance misuse issues;
- to undertake and commission research in relation to mental health and substance misuse issues;
- to support and promote strategies that—
    - prevent mental illness and substance misuse; and

[50] Queensland Health, *Chief Psychiatrist policies,* https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/act/policies-guidelines.

[51] Queensland Mental Health Commission, *About*, https://www.qmhc.qld.gov.au.

  - facilitate early intervention for mental illness and substance abuse;
- to support and promote the general health and wellbeing of people with a mental illness and people who misuse substances, and their families, carers and support persons;
- to support and promote social inclusion and recovery of people with a mental illness or who misuse substances;
- to promote community awareness and understanding about mental health and substance misuse issues, including for the purpose of reducing stigma and discrimination;
- to take other action the commission considers appropriate to address the needs of relevant persons.[52]

In exercising its functions under the *Mental Health Commission Act 2013*, the commission must:

- focus on systemic mental health and substance misuse issues; and
- take into account comorbid issues including disability, chronic disease and homelessness; and
- take into account issues for people with mental health and substance misuse issues in the criminal justice system; and
- engage and consult with—
  - people with mental health or substance misuse issues, and their families, carers and support persons; and
  - Hospital and Health Boards under the *Hospital and Health Boards Act 2011*; and
  - the government, non-government and private sectors; and
  - other members of the community to the extent the commissioner considers appropriate; and
- take into account the particular views, needs and vulnerabilities of different sections of the Queensland community, including—
  - Aboriginal and Torres Strait Islander communities; and
  - culturally and linguistically diverse communities; and
  - regional and remote communities; and
  - other groups at risk of marginalisation and discrimination; and
- take into account contemporary evidence and relevant policy and strategic frameworks.[53]

The QMHC partners with people with lived experience, their families, carers and supporters, as well as decision-makers, funders, advocates, frontline workers and service providers in both government and non-government sectors to drive reform.[54]

2.4.2.1 Shifting Minds

Shifting Minds - Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023 (Shifting Minds) is a strategic plan developed by the QMHC, and aims to address critical areas that will

[52] *Queensland Mental Health Commission Act 2013* s 11(1).

[53] *Queensland Mental Health Commission Act 2013* s 11(2).

[54] Queensland Mental Health Commission, *Our work*, https://www.qmhc.qld.gov.au.

facilitate the systemic change required to create new and improved opportunities for individuals, families, carers and communities.[55]

The focus of the five year plan goes beyond connecting people to services and aims to ensure the best possible quality of life for all Queenslanders through good mental health and wellbeing and social and economic inclusion and participation.[56]

The vision outlined in Shifting Minds is:

> A fair and inclusive Queensland where all people can achieve positive mental health and wellbeing and live lives with meaning and purpose.[57]

Shifting Minds outlines three areas of focus to achieve this vision:

- better lives: focuses on individuals and aims to personalise and integrate care, as well as remove barriers to social and economic participation
- invest to save: focuses on populations and early intervention, aiming to strengthen mental health and wellbeing
- whole-of-system improvement: is systems focused and looks toward a balanced approach and collective responsibility, including whole-of-government leadership and accountability.[58]

2.4.2.2 Every life

Every Life: The Queensland Suicide Prevention Plan 2019-2029: Phase One (Every Life) was developed by the QMHC and is a 3-phase 10-year plan.[59] Phase one (2019-22) is based on shared responsibility and has 4 action areas:

- Building resilience: Improve wellbeing in people and communities
  - 'Building resilience' has a strong focus on school and workplace supports, and creating mentally healthy workplaces and wider communities. It identifies that the Queensland Government, as the state's largest employer, must lead by example.
- Reducing vulnerability: Strengthen support to vulnerable people
  - 'Reducing vulnerability' focuses on identifying and supporting vulnerable populations so interventions are targeted and effective.
- Enhancing responsiveness: Enhance responses to suicidality
  - 'Enhancing responsiveness' looks at ensuring there is accessible and effective care options and interventions for people who may be distressed or suicidal. It also identifies that Queensland's health system should strive to be a leader in the care of people who are suicidal. Providing ongoing support to individuals and communities following a suicide was identified as needing to be both timely and accessible.
- Working together: Achieve more by working together

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55 Queensland Mental Health Commission, *Shifting Minds - Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023.*

56 Queensland Mental Health Commission, *Shifting Minds - Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023,* p 6.

57 Queensland Mental Health Commission, *Shifting Minds - Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023,* p 6.

58 Queensland Mental Health Commission, *Shifting Minds - Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023,* p 6.

59 Queensland Mental Health Commission, *Every Life: the Queensland Suicide Prevention Plan 2019-2029*.

- 'Working together' focuses on creating a coordinated approach to suicide prevention, across national, state, regional and local levels. There is also a focus on a community-led approach to suicide prevention in Aboriginal and Torres Strait Islander communities to ensure effectiveness. [60]

2.4.2.3 Queensland Framework for the Development of the Mental Health Lived Experience Workforce

The purpose of the *Queensland Framework for the Development of the Mental Health Lived Experience* (Queensland Lived Experience Framework) is to support the development and expansion of lived experience roles across Queensland.[61]

The Queensland Lived Experience Framework seeks to:

- increase understanding of the value and functions of lived experience and provide clear information for organisations on how to structure and support lived experience roles
- provide a detailed framework that can support the development/expansion of lived experience roles across Queensland and improve collaboration within mental health settings.[62]

The Queensland Lived Experience Framework is also intended to be broad, flexible, adaptive and evolve over time.[63]

60 Queensland Mental Health Commission, *Every Life: the Queensland Suicide Prevention Plan 2019-2029*, pp 4-5.

61 Queensland Mental Health Commission, *Queensland Framework for the Development of the Mental Health Lived Experience Workforce*.

62 Queensland Mental Health Commission, *Queensland Framework for the Development of the Mental Health Lived Experience Workforce*, p 1.

63 Queensland Mental Health Commission, *Queensland Framework for the Development of the Mental Health Lived Experience Workforce*, p 1.

3 Queensland's mental health service system

Mental health services in Queensland are provided through the public, private and non-government sectors.[64] This part of the report describes the services provided by each sector.

Arrangements are in place between the Australian Government and the state and territory governments which determine the roles and responsibilities when delivering mental healthcare services.[65]

3.1 Australian Government

The Australian Government funds PHNs to plan and commission health services, including mental health and AOD services.[66]

3.1.1 Primary health networks

There are 7 PHNs in Queensland aligned to Hospital and Health Services (HHSs) boundaries. PHNs are expected to 'work closely with Queensland Health, the local HHS and local stakeholders to undertake joint planning and put in place mechanisms to connect health services for people to encourage better use of health resources and avoid duplication'.[67]

PHNs do not directly deliver primary health services. Rather, PHNs use Australian Government funding to contract providers to deliver health services, including mental health and AOD services, to patients within their community.[68]

Queensland Primary Health Networks (Queensland PHNs/QPHNs) explained how PHNs operate:

> The focus of the QPHNs is on primary care through the support of General Practitioners, and working with a range of government and community organisations, service providers and the community to develop and better integrate health and community care services, and improve access to services with an emphasis on those most vulnerable people at risk of poor health outcomes.[69]

3.2 Queensland Health

Queensland Health comprises the Queensland Department of Health (DoH), 16 independent HHSs, and the QAS.

3.2.1 Department of Health

The DoH is responsible for the overall management of Queensland's public health system. The DoH 'funds and enters into service agreements with HHSs and NGOs [non-government organisations] for the delivery of a range of health services, including specialist mental health alcohol and other drugs (MHAOD) treatment'.[70]

The MHAOD Branch within Clinical Excellence Queensland in the DoH undertakes the 'system-wide clinical, policy and planning advice and leadership to support the delivery of safe, quality, evidence-

64 Queensland Mental Health Commission, briefing paper, 20 January 2022, p 11.

65 For example, the *National Health Reform Agreement 2020-2025* and *The Bilateral Schedule on Mental Health and Suicide Prevention: Queensland.*

66 Queensland Health, briefing paper, 1 February 2022, p 8.

67 Queensland Health, briefing paper, 1 February 2022, p 8.

68 PHN Central Queensland, Wide Bay, Sunshine Coast, '*Commissioning*', https://www.ourphn.org.au/commissioning/.

69 Queensland Primary Health Networks, submission 52 to the Queensland Parliament Community Support and Services Committee's *Inquiry into social isolation and loneliness in Queensland*, p 3.

70 Queensland Health, briefing paper, 1 February 2022, p 9.

based clinical and non-clinical MHAOD services'.[71] Queensland Health advised that there is 'a commitment to actively involve the voice of lived experience in the work of and key projects undertaken by the MHAOD Branch'.[72]

The strategic work of the MHAOD Branch is guided by *Shifting Minds*, the Queensland mental health alcohol and other drugs strategic plan (see section 2.4.2.1 for more information on the plan).[73]

3.2.2 Health and Hospital Services

HHSs are independent statutory bodies that are governed by a Hospital and Health Board in accordance with the *Hospital and Health Boards Act 2011*.[74] There are 16 HHSs across the state.[75]

HHSs are responsible for the delivery of public sector health services to their designated geographic area, including public mental health and AOD services.[76]

Public mental health and AOD services work in collaboration with primary health and private sector health providers who assist individuals with mental health problems and facilitate access to specialist public and private mental health services when required.[77]

The public mental health system in Queensland provides:

- hospital bed-based services (acute and medium secure)
- community bed-based services (community care units, adult and youth step-up/step-down, older persons non-acute, AOD rehabilitation)
- community treatment services (child and youth, adult, older persons, AOD)
- state-wide and specialist services, including the Queensland Transcultural Mental Health Centre which provides culturally response mental healthcare and support to people from culturally and linguistically diverse (CALD) backgrounds
- forensic high secure and extended treatment beds and state-wide community forensic services
- eating disorder services, including beds
- perinatal and infant mental health services, including mother-infant beds
- suicide prevention crisis services
- community-based psychosocial support services through NGOs for those not receiving support through the National Disability Insurance Scheme (NDIS).[78]

Mental health and AOD services delivered by HHSs were directly accessed by 132,000 Queenslanders in 2020-21, resulting in 84,000 episodes of mental healthcare treatment. Seventy per cent of the care

71 Queensland Health, briefing paper, 1 February 2022, p 9.

72 Queensland Health, briefing paper, 1 February 2022, p 9.

73 Queensland Health, briefing paper, 1 February 2022, p 10. See Queensland Health, submission 150, p 16 for further relevant policies and plans.

74 Queensland Health, briefing paper, 1 February 2022, p 9.

75 Cairns and Hinterland, Central Queensland, Central West, Children's Health Queensland, Darling Downs, Gold Coast, Mackay, Metro North, Metro South, North West, South West, Torres and Cape, Townsville, West Moreton and Wide Bay.

76 Queensland Health, briefing paper, 1 February 2022, p 10.

77 Queensland Health, *Queensland mental health services*, https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/clinical-staff/mental-health/services.

78 Queensland Mental Health Commission, briefing paper, 20 January 2022, pp 11-12.

occurred in community-based settings.[79] Queensland Health provided the following breakdown of the referrals:

> One-quarter of referrals for mental health care were received from emergency departments and more than half of referrals were to an Acute Care Team. The three main reasons individuals were referred for assessment and treatment are emotional, behavioural, and mental health issues (30.4 per cent), suicide or self-harm related (22.5 per cent) and anxiety, depression, or coping issues (9.3 per cent).[80]

Nearly 20,000 individuals accessed HHS delivered AOD services with 64% of these being males. Queensland Health advised:

> The most common age group of clients is 20-29 years. More than 24,000 episodes of treatment were for own drug use with the three main drugs for which clients sought treatment being alcohol (41 per cent), cannabis (30 per cent) and amphetamines (13 per cent). The most common treatment provided was assessment.[81]

3.2.3 Queensland Ambulance Service

As the legislated provider of pre-hospital emergency healthcare in Queensland, QAS has an important role in responding to people experiencing a mental health crisis.

Thirteen per cent of the emergencies responded to each year by the QAS (around 170,000) are for a mental health crisis. Calls to Triple Zero from people experiencing mental health crisis are usually the second most frequent type of call, after falls.[82] The QAS has seen an upward trend for calls for people experiencing a mental health crisis of between 15% to 20% each year for the past 5 years.[83]

The QAS describes a mental health crisis as any situation where a person feels that they are unable to cope with the stressors of life, leading to distress and suffering, requiring alleviation or care, and can include exacerbation of an existing mental health condition, suicide crisis, significant life events, domestic violence, drug and alcohol use/issues.[84]

The assessment and care of people experiencing a mental health crisis prove challenging for the QAS. To support paramedics and Emergency Medical Dispatchers (EMDs), there is the QAS Mental Health Response Program.[85] The program includes a Mental Health Liaison Service (MHLS) available state-wide 24 hours a day,[86] and Mental Health Co-Responders in selected areas.[87] (See section 6.4.2.2 for more information.)

3.3 Private sector

The private sector provides treatment for 'high-prevalence mental health conditions, particularly depression, anxiety, personality, eating disorders and drug and alcohol addiction'.[88] Private hospital insurance is often used to pay for inpatient psychiatric treatment or drug and alcohol treatment.

79 Queensland Health, briefing paper, 1 February 2022, p 13.

80 Queensland Health, briefing paper, 1 February 2022, p 13.

81 Queensland Health, briefing paper, 1 February 2022, p 13.

82 Queensland Health, submission 150, p 125.

83 Queensland Health, submission 150, p 125.

84 Queensland Health, submission 150, p 125; Queensland Health, briefing paper, 1 February 2022, p 13.

85 Queensland Health, submission 150, p 128.

86 The MHLS is a senior mental health clinician working in the Brisbane Operations Centre.

87 As at 2021: Gold Coast, West Moreton, Metro South, Metro North, Sunshine Coast, Cairns and Townsville.

88 Queensland Mental Health Commission, submission 151, p 6.

Extras/ancillary insurance covers out-of-hospital treatments that are not eligible for Medicare Benefits Schedule (MBS) rebates, such as psychology.[89]

In 2019-20, private health insurance paid for 53% of all mental healthcare separations in Australian hospitals, with the private hospitals' sector dealing with 60% of cases. In-hospital mental healthcare claims totalled $628 million, with a further $31.8 million paid in psychology/group therapy services under extras/ancillary claims.[90]

While private health insurance funds private hospital stays, private psychiatrists, and allied health professional sessions, the QMHC noted that 'both the MBS and private health insurance require a gap payment due to the limited number of service providers that provide bulk-billing arrangements'.[91]

3.4 Non-government sector

Queensland Health advised that NGOs deliver mental health services, including individual and group psychosocial support and counselling, family and carer support. Queensland Health added:

> AOD NGO delivered services include residential and non-residential rehabilitation, psychosocial intervention, residential withdrawal management, family support services, needle and syringe and other harm reduction programs and police and court diversion health interventions. The Queensland Opioid Treatment Program (QOTP) is also delivered by private prescribers (predominantly General Practitioners) and pharmacies.[92]

In 2020-21, there were 79,000 attendances at mental health NGOs and more than 12,000 bed days were utilised. Nearly 15,000 people accessed an AOD service at an AOD NGO, most commonly counselling.[93]

3.5 Aboriginal Community Controlled Health Organisations

An Aboriginal Community Controlled Health Organisation (ACCHO) is a primary healthcare service 'initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it, through a locally elected Board of Management'.[94] Across Australia, over 140 ACCHOs provide 3.1 million episodes of care per year for nearly 410,000 people across Australia.[95]

89 Queensland Mental Health Commission, submission 151, p 6.

90 Queensland Mental Health Commission, briefing paper, 20 January 2022, p 16.

91 Queensland Mental Health Commission, briefing paper, 20 January 2022, p 38.

92 Queensland Health, briefing paper, 1 February 2022, p 10.

93 Queensland Health, briefing paper, 1 February 2022, p 13.

94 National Aboriginal Community Controlled Health Organisation, '*What is an ACCHO*?', https://www.naccho.org.au/acchos/.

95 National Aboriginal Community Controlled Health Organisation, '*Who we are'*, https://www.naccho.org.au/about-us/.

4 Funding of mental health services

The issue of funding of mental health and AOD services arose frequently during the committee's inquiry, with some stakeholders advocating for more funding and/or more consistent funding for services.[96]

While consumers, private health insurers and other non-government funders (eg workers' compensation schemes) provide some funding for mental health services, the Australian and Queensland Governments fund the majority of mental health services in Queensland.[97]

According to the Productivity Commission, a number of national initiatives and nationally agreed strategies and plans underpin the delivery and monitoring of services for mental health in Australia, including:

- the *Mental Health Statement of Rights and Responsibilities* (Australian Health Ministers 1991)
- the *National Mental Health Policy 2008* (Department of Health (Australian Government) 2009)
- the *National Mental Health Strategy* (Department of Health (Australian Government) 2014)
- 5-yearly National Mental Health Plans, with the most recent — the Fifth National *Mental Health and Suicide Prevention Plan*[98] — endorsed in August 2017 (Council of Australian Governments 2017).[99]

The Productivity Commission explained the roles of the state and federal governments:

> State and Territory governments are responsible for the funding, delivery and/or management of specialised services for mental health including inpatient/admitted care in hospitals, community-based ambulatory care and community-based residential care.
>
> The Australian Government is responsible for the oversight and funding of a range of services for mental health and programs that are primarily provided or delivered by private practitioners or NGOs.[100]

While responsibility for the funding and regulation of mental health services in Australia is shared between the Australian and state and territory governments, their respective roles are not always clear.[101]

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96 See, for example, submissions 4, 12, 25, 150, and 151.

97 Australian Government, Australian Institute of Health and Welfare, *Australia's health 2020 data insights*, 2020, p 160.

98 On 4 August 2017, the Council of Australian Governments agreed to the *Fifth National Mental Health and Suicide Prevention Plan*, which established a national approach for collaborative government effort from 2017 to 2022.

99 Productivity Commission, *Report on government services*, 'Part E - Health', Chapter 13: Services for mental health, released 1 February 2022, p 3 of 44, https://www.ProductivityCommission.gov.au/research/ongoing/report-on-government-services/2022/health/services-for-mental-health.

100 Productivity Commission, *Report on government services 2022*, 'Services for mental health', https://www.ProductivityCommission.gov.au/research/ongoing/report-on-government-services/2022/health/services-for-mental-health.

101 Parliament of Australia, Department of Parliamentary Services, *Mental health in Australia: a quick guide*, Research Paper Series, 2018-19, 14 February 2019, p 3.

The reality of mental health funding is further complicated by 'a fragmented landscape of service providers across Commonwealth and State government, private, primary health, and non-government organisations'.[102]

The Productivity Commission reported that distortionary funding arrangements and unclear government responsibilities beset the planning, funding and delivery of mental health services.[103]

The Productivity Commission added:

- Australian Government and state and territory governments responsibilities for clinical mental healthcare, psychosocial supports, suicide prevention services, and mental health carer supports are neither clear nor consistently implemented — either in intergovernmental agreements or 'on the ground' …
- mechanisms for funding mental health services create incentives to direct consumers toward hospital-based care and MBS-rebated care ahead of other forms of mental health services, permit low productivity among services such as community ambulatory mental healthcare, and prevent private insurers from investing in the mental health of their consumers …[104]

This section of the report looks at how mental health services are funded, the money expended on services, and some issues related to funding.

4.1 Australian Government mental health expenditure

4.1.1 Medicare Benefits Schedule

The largest proportion of expenditure by the Australian Government on mental health services is spent on MBS subsidised services.[105]

The Australian Government subsidises certain mental health services through the MBS, including 'a range of general practitioner (GP), allied health professional, and specialist mental health treatment and care services'.[106] These services are delivered in community settings (eg consulting rooms) or for inpatient services (eg private hospitals). Unless bulk-billed, many of the services require a co-payment from the service user.[107]

As regards the number of Queenslanders who receive services subsidised by Medicare, the QMHC advised:

> In 2019-20, … 9.3 per cent (474,697 people) of the population in Queensland, received Medicare-subsidised mental health-specific services provided by general practitioners. Approximately 2.2 per cent (111,045 people) of the Queensland population received a Medicare-subsidised mental health service provided by a clinical psychologist. … 3.3 per cent (168,223 people) received a Medicare-subsidised mental health service provided by 'other psychologists'.[108]

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102 Queensland Mental Health Commission, submission 151, p 4.

103 Productivity Commission, *Mental health inquiry report,* No. 95, 2020, vol 3, p 1133.

104 Productivity Commission, *Mental health inquiry report,* No. 95, 2020, vol 3, p 1135.

105 Productivity Commission, *Report on government services*, 'E Health', 13 Services for mental health, released 1 February 2022, p 3 of 44, https://www.Productivity Commission.gov.au/research/ongoing/report-on-government-services/2022/health/services-for-mental-health.

106 Queensland Health, briefing paper, 1 February 2022, p 33.

107 Queensland Health, briefing paper, 1 February 2022, p 33.

108 Queensland Mental Health Commission, briefing paper, 20 January 2022, p 16. But see Queensland Health, briefing paper, 1 February 2022, p 33 which states 'In 2019-20, 11.2 per cent of the Queensland population received a Medicare-subsidised mental health-specific service'.

With respect to Medicare-subsidised mental health services, Queensland Health advised:

> In 2018-19, the latest time period for which data is available shows that Commonwealth Government expenditure on mental-health specific services in Queensland was almost $271.8 million, a per capita rate of $53.81. This per capita rate was second only to expenditure in Victoria ($57.94) and higher than the Australian average ($51.45).[109]

4.1.2 Australian veterans

The Australian Government pays for veterans' mental health services through the RPBS, Repatriation Medical Benefits (GPs, allied health professionals, and psychiatrists), services provided through public and private hospitals and grants to organisations delivering mental health related services.[110]

The Australian Government also funds psychosocial supports both through and outside the NDIS.[111]

4.1.3 Psychosocial disability

The Australian Government funds the NDIS for the provision of services to people with psychosocial disabilities. It also funds programs for people experiencing psychosocial disability who require support but are yet to apply for, or receive their NDIS package, or who have been deemed ineligible for an NDIS package.[112]

4.1.4 Primary Health Networks

Brisbane South PHN advised that Queensland PHNs 'fund around $150 million a year in mental health and suicide prevention services'.[113] These funded services are mainly provided by not-for-profit NGOs and the remainder by private providers.[114] Brisbane South PHN advised:

> In terms of numbers, this supports 55,000 individuals. It also accounts for over 460,000 occasions of service across the state, including remote and very remote areas such as Western Queensland.[115]

With respect to the Brisbane South PHN itself:

> Of the $45 million we get, just under $30 million is spent on what we call mental health, alcohol and other drugs. A significant part of what we receive from the Commonwealth is invested in mental health and mental health services. A large chunk of that is in established programs like headspace which will go on year to year. What we do commission we do not commission for the next six months or the next 12 months; we look to commission for a period of time extended beyond that. A successful PHN will have understood the needs of its community for the next three years and will commission accordingly.[116]

4.1.5 National Health Reform Agreement

Under the *National Health Reform Agreement* (NHRA), the Australian Government contributes funds to the states and territories for public hospital services.[117]

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109 Queensland Health, briefing paper, 1 February 2022, p 33.

110 Queensland Health, briefing paper, 1 February 2022, pp 7-8, 33-34.

111 Queensland Health, briefing paper, 1 February 2022, pp 7-8, 33-34.

112 Queensland Health, briefing paper, 1 February 2022, p 34.

113 Public hearing transcript, Brisbane, 17 February 2022, p 1.

114 Public hearing transcript, Brisbane, 17 February 2022, p 1.

115 Public hearing transcript, Brisbane, 17 February 2022, p 1.

116 Public hearing transcript, Brisbane, 17 February 2022, p 5.

117 Australian Government, Department of Health, '2020-25 National Health Reform Agreement (NHRA)', https://www.health.gov.au/initiatives-and-programs/2020-25-national-health-reform-agreement-nhra.

The NHRA sets out a model for funding public hospitals using Activity Based Funding (ABF) which means hospitals get paid for the number and mix of patients they treat, taking complexity into account. If the ABF approach cannot be used for a public hospital, a block funding approach is used.[118]

Public hospitals also receive funding from other sources (eg the Australian and state governments, and third parties) for providing functions and services outside the scope of the NHRA (eg pharmaceuticals, primary care, home and community care, dental services, residential aged care and disability services).[119]

Queensland Health explained:

> At the 1 April 2016 Council of Australian Governments (COAG) meeting, COAG agreed to the National Health Reform Agreement. This agreement will continue the Commonwealth funding 45 per cent of the growth of public hospital services for the three years spanning 2017-18 to 2019-20, although growth in Commonwealth public hospital funding will be capped so that it does not exceed six and a half per cent (6.5%) per year across the State.
>
> The Prime Minister and Premiers of all States and Territories signed Schedule I - Addendum to the NHRA in June 2017, which came into effect on 1 July 2017. It includes:
>
> - the introduction of a data conditional payment to encourage the prompt provision of required data
> - a six and a half per cent cap on the growth of Commonwealth National Health Reform funding
> - the incorporation of safety and quality into hospital pricing and funding (for sentinel events, hospital acquired complications and re-admissions)
> - reforms to primary care to reduce potentially avoidable hospital admissions
> - better coordinated care for patients with chronic and complex disease.[120]

4.2 Queensland Government mental health expenditure

In 2020-21, Queensland Health spent an estimated $1.49 billion on mental health and AOD services. Most of this ($1.35 billion or 91%) was spent on mental health, with the remainder (approximately $139 million) on AOD.[121]

About 89% ($1.2 billion) of the $1.35 billion was spent on treatment delivered through HHSs and 5% ($63.6 million) was spent on psychosocial support services delivered through NGOs.[122]

Of the approximately $139 million spent on AOD in 2020-21, 61% ($85.4 million) was spent on treatment delivered through HHSs and 36% ($49.7 million) for treatment delivered through the NGO sector.[123]

4.2.1 Hospital and health service mental health services

Queensland Health advised that it uses a mixed model to fund mental health services. In broad terms this includes:

- admitted patient (separations)

[118] Queensland Health, briefing paper, 1 February 2022, pp 13-14.

[119] National Health Funding Body, 'Calculate', https://www.publichospitalfunding.gov.au/public-hospital-funding/calculate.

[120] Queensland Health, *Health funding policy and principles: 2019-20 financial year*, version 3.0, p 3.

[121] Queensland Health, briefing paper, 1 February 2022, p 15.

[122] Queensland Health, briefing paper, 1 February 2022, p 16.

[123] Queensland Health, briefing paper, 1 February 2022, p 16.

- specialised admitted patient services in acute hospitals are funded via a day rate, with the rate varying based on the type of service (ie general acute, child acute, secure rehab etc)
- non-specialised mental health activity in acute hospitals that occurs outside of specialised units is funded via a broader model (based on Diagnostic Related Groups)
- all admitted activity that occurs in public psychiatric hospitals is block funded.

- community and residential services which are block funded.[124]

AOD services delivered by HHSs are largely block funded 'using a population-base model for primary health and community services'.[125]

4.2.2 Non-government organisation service funding

The DoH provides funding to NGOs for a range of healthcare services, including mental health community support services.[126] The QMHC advised that 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'.[127]

The DoH funds NGOs to provide AOD treatment services, including specialist treatment and support services.[128]

4.3 Consumers

Consumers accessing treatment for mental illness can face high out-of-pocket costs. Potential out-of-pocket costs include:

- the gap between the fee for a GP consultation (such as to prepare a mental health plan) and the amount rebated by Medicare
- the cost of prescription medicines to consumers after the subsidy under the PBS has been applied
- the gap between the fee for a psychologist or psychiatrist consultation and Medicare rebate amount or the person's private health insurance (if they have cover)
- the gap between the fee for private hospital in-patient treatment and the Medicare rebate amount and the person's health insurance (if they have cover)
- the cost of private prescription medicines (those not under the PBS)
- the full cost of a psychologist consultation not covered by Medicare: for example, after a consumer has exhausted their Medicare entitlement
- fees for online mental health services, such as some online treatment courses
- the cost of traveling to and from appointments

[124] Queensland Health, briefing paper, 1 February 2022, p 14.

[125] Queensland Health, briefing paper, 1 February 2022, p 15.

[126] Queensland Health, briefing paper, 1 February 2022, p 15. Queensland Health notes that, in general, service agreements with NGO providers are generally for a 5-year term.

[127] Queensland Mental Health Commission, submission 151, p 6.

[128] Queensland Mental Health Commission, submission 151, p 6.

- the cost of accommodation when travelling for treatment.[129]

In addition, consumers may pay for private health insurance.[130]

4.4 Issues raised about the funding of mental health services

4.4.1 Level of mental health funding in Queensland

Overall health expenditure in Queensland has increased over recent years, but there has not been a corresponding increase in mental health expenditure (see Figure 1 below).[131]

Queensland Health advised:

> … while there has been a growth of 62 per cent in per capita expenditure on public hospital and health services between 2009 and 2018-19 in Queensland, comparatively mental health per capita expenditure has only increased by 10 per cent during the same time period despite significant recent investment.[132]

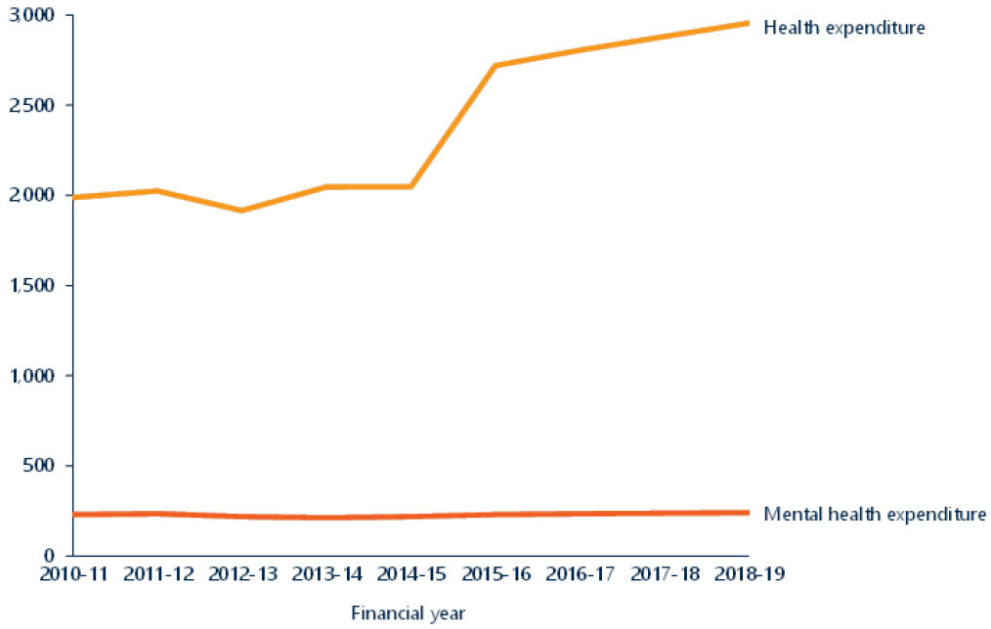

Figure 1 – Proportion of Queensland Health spend on mental health services[133]

The Chair of the Queensland Branch of the Royal Australian and New Zealand College of Psychiatrists (RANZCP Queensland Branch) made the following comments about the level of funding provided for mental health services:

> Mental health services are the poor cousins of health. Alcohol and drug services are the very poor cousins of mental health. We have tragically low funding.[134]

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129 Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 153.

130 The Australian Government provides a rebate to help cover the cost of premiums: Australian Government, AIHW, 'Private health insurance', 23 July 2020, https://www.aihw.gov.au/reports/australias-health/private-health-insurance.

131 Queensland Mental Health Commission, briefing paper, 20 January 2022, pp 12, 13.

132 Queensland Health, public briefing transcript, Brisbane, 20 January 2022, p 2.

133 Queensland Mental Health Commission, briefing paper, 20 January 2022 p 13.

134 Public hearing transcript, Brisbane, 12 April 2022, p 58.

Over the past decade, Queensland's per capita spend on mental health services has been below the national average (see Figure 2 below).[135] In 2019-20, Queensland had the lowest per capita expenditure on mental health services in Australia.[136]

In addition, Queensland's rate of growth in per capita expenditure (5%) between 2010-11 and 2019-20 was at half the national growth rate (10%).[137] Queensland Health advised that in 2019-20, Queensland spent $246.90 per person, $13.59 per person below the national average of $260.49 per person.[138]

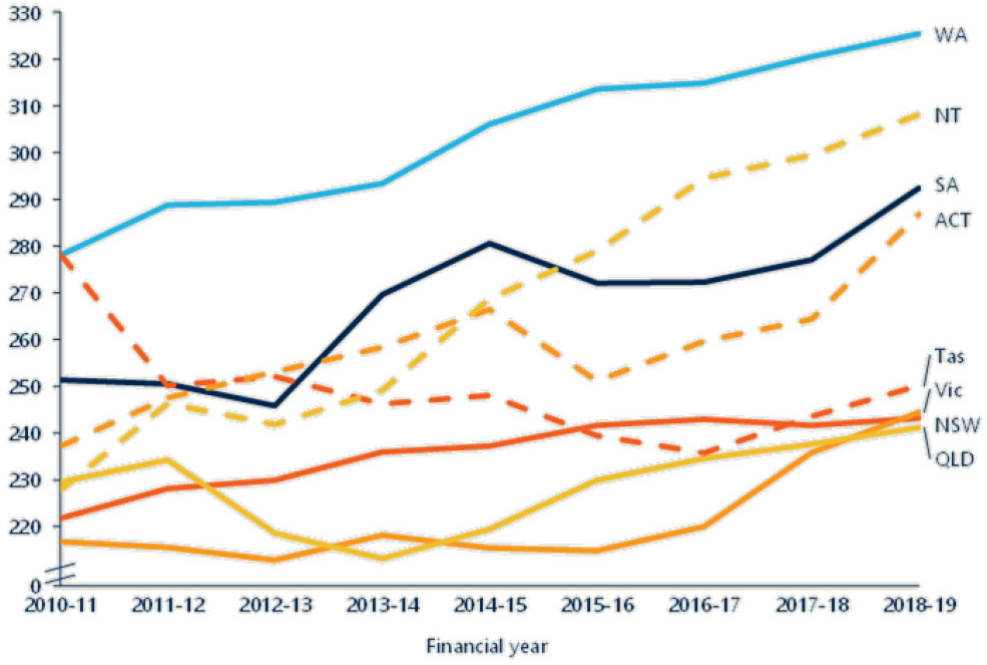

Figure 2 – Mental health expenditure per capita ($) by jurisdiction[139]

Queensland Health noted, however, that Queensland's public health system is very efficient:

> … the Queensland public health system is the second most efficient in cost by how we measure it, in weighted activity units, and what we spend in the block-funded areas of what we do. When you consider that in light of Victoria, which is the most efficient with a centralised system and not a decentralised state, we perform exceptionally well. That is credit to all of the clinicians and components of the system around how well they are performing. When you do look at the per capita spend you also have to overlay that we have an efficient system. If we are running an efficient system then our per capita spend should be slightly lower.[140]

4.4.1.1 Need for increased investment

Stakeholders nevertheless encouraged further investment in mental health services.[141]

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135 Queensland Health, submission 150, p 17; Queensland Health, briefing paper, 1 February 2022, p 30.

136 Queensland Health, submission 150, p 17.

137 Queensland Health, submission 150, p 17; Queensland Health, briefing paper, 1 February 2022, p 30.

138 Queensland Health, submission 150, p 17.

139 Queensland Mental Health Commission, briefing paper, 20 January 2022 p 12.

140 Public briefing transcript, Brisbane, 17 February 2022, p 7.

141 See, for example, submissions 104, 140, 150, and 151.

Associate Professor John Allan, Executive Director, Queensland Health said that he was seeking a large amount of funding but acknowledged that it was unlikely to be achieved in the short term:

> Obviously from my point of view of being a leader in this space, I am looking for an injection of funding; that is pretty clear. The quantum of that is going to be decided by other people, but I think we try to make the case that it is a large amount of money. The planning framework—when I was talking about that 100 per cent—would suggest about $900 million a year to get to 100 per cent of that planning framework. I appreciate that is not going to happen. That is just a step too far and that is something we would look at a 10- or 20-year ambitious plan to get there and hopefully the community would change and our attitudes to mental health and drug and alcohol would change and there would be other changes we would want to make.[142]

The Australian Medical Association Queensland (AMAQ) held the view that the Queensland Government needs a recurrent investment of between $650 million and $700 million per year to address the unmet need in Queensland.[143] The AMAQ added:

> This level of investment is more important than ever due to the impact of the pandemic on the mental health of millions of Queenslanders. This level of funding would be consistent with the $850 million per year on a pro rata basis that the Victorian government committed following its royal commission into Victoria's mental health services—so on the same sort of page as Victoria per head of population.[144]

The RANZCP called for an immediate funding increase of $88 million per year 'to bring Queensland mental health spending up to the national average' and for a recurrent annual funding increase of up to $750 million per year on a pro rata basis in the longer term, 'to match the Victorian Government funding'.[145] The RANZCP stated:

> If you look at what the mental health system needs, it is funding. The AMA is calling for between $600 million and $700 million; we are calling for about $750 million; and I think John Allan got up and said that he thought, based on the National Mental Health Service Planning Framework, it would be about $900 million. If you look at all the other inquiries that Australia has had—the Victorian one, the New Zealand one, the productivity one—significant funding has followed, and if you pro rata the Victorian investment, that is where I get my $750 million from. Now, we could not spend $750 million now; we are talking about $750 million in five years time, and you probably need to grow funding, if you can, by about $100 million to $120 million a year over those five years.[146]

Mr Shaun Drummond, former Chief Operating Officer and current Acting Director-General, Queensland Health, commented on the $750 million per year proposal by the RANZCP and stated that problems can result from spending money on only part of the mental health system:

> … one of the things it does not take into account is a relative efficiency … it is looking at a per capita spend. There are two complexities in that, as I said: the nature of our regional basis but also how efficient we are as a system. One of the things around those guidelines is that all dollars are not the same. No, I do not believe $750 million is the right amount because it has not taken into account some of our complexity or the spend that is occurring in our system that is not in the paradigm of a mental health service but is for a mental health and alcohol and other drug consumer and is occurring in the acute system. Part of this is the opportunity around how we reorientate that into a stronger model for the community because there is spend occurring elsewhere inside our system that we need to recognise and there is the opportunity on that.

142 Public briefing transcript, Brisbane, 17 February 2022, p 10.

143 Australian Medical Association Queensland, submission 104, p 1; Australian Medical Association Queensland, public hearing transcript, Brisbane, 17 February 2022, p 9.

144 Public hearing transcript, Brisbane, 17 February 2022, p 9.

145 Submission 140, p 4.

146 Public hearing transcript, Brisbane, 12 April 2022, p 57.

> It is a vicious circle for us though. The more effective we get in the acute system, the more likely we are to get activity coming to us. We used the example before of a GP. If you see a GP and you go off to a different site to get pathology and then somewhere else for imaging. If you go to an emergency department you can get all of those in one location and you are not waiting a day or two for an appointment. As we get more and more effective, if we are not matched with that integration and improvement and effectiveness in the other components, what we get is disproportionate growth that is attracted to us. That is where we have to do the joint commissioning that works with so many other partners.
>
> If we took that $750 million and spent that, we are going to attract effectively activity beyond what that was intended for unless we lift the whole system. That includes us working with the Commonwealth.[147]

4.4.1.2 Issues with capped Australian Government funding

Mr Drummond then explained that capped Australian Government funding is a significant problem for Queensland:

> One of the big problems that we have with the Commonwealth funding is that it is capped. This year is going to be a problematic year for us because the Commonwealth is capping at an approximately 2½ per cent volume increase in terms of what their model will give us as a system. While they might be recognising some of the cost pressures from two years ago—because that is how the system works: cost pressures from two years ago cascades into what it pays today, so it does not have COVID costs in how that has been set. Then because we are capped at 6½ per cent the volume gets what is left after cost escalation. We are facing a significant pressure because if we lift as a state, we are already at the cap and so we are not going to get Commonwealth contribution if it is coming out of the cap. There has to be a reset of this not just at a state level but at a Commonwealth level to recognise this.[148]

Mr Drummond added that current funding models do not deal well with bundling (ie looking at all the services provided to a consumer). According to Mr Drummond, the challenge is how to commission effectively so that the funding provides the appropriate intervention for the patient.[149] At the moment, however, Queensland Health is primarily funded for the acute component:

> … the funding models at the moment do not react well to what we would call bundling. The bundling is to look at all of the services that are going into a consumer or a member of the community and how we can effectively commission that. That is some of what Ivan [the Queensland Mental Health Commissioner] was talking about. If we can bundle that together, we can put in that funding pool to get the right modality, the right location whether it is in a regional or rural area across that whole intervention for the patient. At the moment under our model we are funded primarily for the acute component. Unless we can bundle across that, we will never have that impact of lifting everybody. If one single component lifts, that is where the pressure is going to be attracted to. It creates a gravity to it. That is our challenge.[150]

4.4.2 Pharmaceutical Benefits Scheme

The Australian Government subsidises a wide range of mental health related pharmaceuticals under the Pharmaceutical Benefits Scheme (PBS) and the Repatriation Pharmaceutical Benefits Scheme (RPBS). Under these schemes, most people make co-payments which depend on their concessional status and whether they have reached the safety net threshold.[151]

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147 Public briefing transcript, Brisbane, 17 February 2022, p 10.

148 Public briefing transcript, Brisbane, 17 February 2022, p 10.

149 Public hearing transcript, Brisbane, 17 February 2022, p 10.

150 Mr Shaun Drummond, Chief Operating Officer, Queensland Health, public hearing transcript, Brisbane, 17 February 2022, p 10.

151 Queensland Health, briefing paper, 1 February 2022, p 33.

In 2018-19, the Australian Government spent $117,115 million ($23.19 per capita) on mental health-related medications in Queensland under the PBS and RPBS. Nationally, this was the highest per capita expenditure for a state or territory.[152]

4.4.3 Mental health funding models

Queensland Health posited that the funding models for mental health have contributed to the low levels of funding for mental health and AOD services over a number of years, but that Queensland Health has started addressing the issue:

> … the funding models that are historic tend to produce the same thing next year and there needs to be a radical look and change at that. We have done some of that recently, but there obviously needs to be more.[153]

As noted above, both ABF and block funding models are used to fund hospitals and mental health services. The QMHC stated that ABF funding has both positive and negative aspects:

> From a positive perspective, it appears that inpatient ABF funding for mental health care gives a good economic signal of the potential cost of follow-up care for people through public community mental health services, which are currently not ABF funded.
>
> However, people are also identifying potentially perverse incentives in ABF, such that beds may be occupied for the optimal duration of time to maximise funding, not on clinical need.
>
> ABF can also negatively impact funding levels and the efficiency of services, as some patients may be difficult to discharge. Such persons may stay longer than the optimal time, which reduces the level of payment under ABF.[154]

4.4.3.1 Joint planning

Brisbane North PHN supported collaboration between the PHNs and HHSs to get the most out of the available funding but recognised that there are some barriers to joint planning, including that HHSs do not receive any operational funding for joint planning. Brisbane North PHN explained:

> We need all the funders around the table working together to make effective use of the money that we have.
>
> The other challenge in joint regional planning to date has been that the HHSs have received no funding to do that. PHNs get a bit of funding from the Commonwealth to do that as part of our operational funds but the HHSs do not get anything. They had to scrape together a couple of hours from someone's position to go out and work with the PHNs. Some were able to find more than others. They need to be resourced to be at the table as equal partners. They have much more money than we have overall but they have much less staffing capacity to engage in this type of true co-design regional planning. That is needed as well.[155]

Brisbane South PHN supported joint planning so as to reduce duplication between HHSs and PHNs:

> Typically in duplication there is often an increase over what it effectively should cost. I would strongly recommend that we approach that at joint regional planning and then joint co-commissioning and then decide whether there is a sufficient pot or that pot needs to be increased.[156]

4.4.3.2 Co-commissioning

Co-commissioning occurs when two or more commissioners/funders of health or social services (such as PHNs and HHSs) jointly address an issue. The co-commissioning may range from 'joint planning and

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152 Queensland Health, briefing paper, 1 February 2022, p 33.

153 Public briefing transcript, Brisbane, 20 January 2022, p 7.

154 Queensland Mental Health Commission, briefing paper, 20 January 2022, p 38.

155 Public hearing transcript, Brisbane, 17 February 2022, p 5.

156 Public hearing transcript, Brisbane, 17 February 2022, p 6.

coordinating of separate commissioning activities all the way through to the pooling of funds and procuring services together'.[157]

Commissioning is a cyclical process.[158] It typically involves:

- assessing needs
- planning services
- co-design
- procuring services
- monitoring quality
- evaluating outcomes.[159]

Brisbane South PHN explained the commissioning process:

> PHNs analyse the local health system and health needs of their communities to identify service gaps or inefficiencies. They then commission services which respond to these needs or gaps and address the population's health needs.[160]

Brisbane South PHN provided the following example of a co-commissioning with Metro South HHS:

> Brisbane South PHN is utilising the Metro South HHS Capability Framework to provide consistent upskilling across the primary care mental health sector on key areas including trauma informed practice, family therapy and physical health.
>
> The first shared service provider capability training commenced with Dialectic Behavioural Therapy (DBT). DBT and DBT-based skills are effective in supporting people with emotional dysregulation concerns, who may tend to repeatedly present in crisis to mental health and emergency services.
>
> This project was co-commissioned by Metro South HHS and Brisbane South PHN in response to the clear shortage of DBT-informed practitioners in Brisbane South and high demand for the services.
>
> We worked closely together to develop and implement a training package that provided multilevel DBT training across the HHS and primary care sector. Sharing resources and providing consistent skills-based training across the services has resulted in increased access to the evidence-based intervention in multiple touchpoints across the system. Early indications suggest this approach is improving patient outcomes, which decreases the need for these patients to access HHS services.[161]

With respect to co-commissioning, Brisbane South PHN recommended that HHSs 'should have the flexibility to co-design and co-commission initiatives that support integrated care pathways and place-based responses to the unique needs of their region'.[162]

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157 Beacon Strategies, 'Co-commissioning health services: the (not so) new frontier for PHNs', blog, 27 March 2019, https://beaconstrategies.net/beacon-strategies-blog/2019/3/27/co-commissioning-health-services-the-not-so-new-frontier-for-primary-mental-health-networks-phns.

158 PHN Central Queensland, Wide Bay, Sunshine Coast, 'Commissioning', https://www.ourphn.org.au/commissioning/

159 'PHNs and regional commissioning', October 2020, https://www.ourphn.org.au/wp-content/uploads/PHNs-and-Regional-Commissioning-Fact-Sheet_Final-2.pdf.

160 Submission 87, p 2. See also 'PHNs and regional commissioning', October 2020, https://www.ourphn.org.au/wp-content/uploads/PHNs-and-Regional-Commissioning-Fact-Sheet_Final-2.pdf

161 Submission 87, p 12.

162 Submission 87, p 4.

For more information and recommendations about regional planning for delivering mental healthcare services and closing the gap on services see section 6.6.

4.4.3.3 Funding impacts on non-government organisations

The Queensland Network of Alcohol and Other Drug Agencies (QNADA) advised that short-term funding for NGOs, and not knowing whether the funding will be extended, has a negative impact on the services offered by NGOs. This is because the staff of the NGO are concerned about losing their job if the NGO's contract is not renewed; there may be redundancies to pay which take funds from services; and it is detrimental to development of the workforce.[163]

QNADA explained:

> People have mortgages and school fees to pay. They have professional development needs of their own. It takes quite a lot of resilience to walk right up to the end date of a contract and hope that you will have another one so that you still have a job the following week. There are financial impacts for services whereby if they have not made people redundant before the end of the contract they wear the cost of that redundancy, which obviously impacts their ability to deliver, but that money cannot be used to then deliver services.
>
> Perhaps the most significant impact is that it holds back the development of our workforce, which we know we have a shortage of, because people leave to go and work in more secure sectors and then we have to start training from the baseline again. There is not a program in this country that produces job-ready graduates for alcohol and drug services. They require further training—not so much psychologists but social workers and nurses. It is a specialised field. It would make the world of difference to have funding stability. I note the public system has that funding stability. I am sure there is a downside to working in the public system, but workforce stability is not the problem for them.[164]

Another issue identified by QNADA with the current method of 'stop-start funding' of NGOs is that there is 'not necessarily a clear pathway for scaling up once we know an intervention works'.[165]

QNADA noted that the rest of the health system 'does not contract on fixed-term contracts'. The organisation said that it would be better to have rolling contracts with better performance management within the contracting environment.[166]

Drug ARM Queensland considered that block funding is the optimum model because it is able to 'adequately cost resources and ability and form long-term planning and create that stable financial environment required to achieve service outcomes'.[167]

4.4.4 Mental health funding mechanisms and accountability

The Victorian Department of Health discussed Victoria's mental health reform agenda arising from the Royal Commission into Victoria's Mental Health System. In response to the Royal Commission, the Victorian Department of Health advised that it is:

> … working to create a new system to provide earlier, localised and integrated care, with tailored support for infants, children and young people and culturally safe services for Aboriginal Victorians and our diverse community.[168]

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163 QNADA, public hearing transcript, Brisbane, 16 February 2022, p 6. See also Queensland Mental Health Commission, submission 151, p 15.

164 Public hearing transcript, Brisbane, 16 February 2022, p 6.

165 Public hearing transcript, Brisbane, 16 February 2022, pp 10-11.

166 Public hearing transcript, Brisbane, 16 February 2022, p 6.

167 Public hearing transcript, Brisbane, 16 February 2022, p 15.

168 Public hearing transcript, Brisbane, 28 April 2022, p 2.

According to the Royal Commission, to 'realise the ambition for a redesigned system' required additional investment.[169]

The Royal Commission's Interim Report (recommendation 8) called on the Victorian Government to design and implement a new approach to mental health investment comprising:

- a new revenue mechanism (a levy or tax) for the provision of operational funding for mental health services
- a dedicated capital investment fund for the mental health system. [170]

The Royal Commission's Interim Report noted:

> This new approach should support a substantial increase in investment in Victoria's mental health system, supplementing the current level and future expected growth of the state's existing funding commitments.[171]

The Royal Commission considered this approach necessary to address the historical underinvestment in mental health services and to provide the community confidence that reforms to the mental health system will be enduring.[172]

When asked whether Queensland Treasury had assessed funding models of other jurisdictions, the Under Treasurer advised:

> … we certainly review state budgets and see where money is being invested. I have alluded to Victoria. They have been the ones, from a funding perspective, if that is the question, that have certainly made a significant investment of some several billion dollars over the next four years in their last budget. The intention is to spend some $3.8 billion over four years on mental health. That has been matched with a mental health and wellbeing levy, which is a $2.9 billion measure that over the next four years will see that money earmarked for their mental health investment. That is probably the more significant funding measure I have seen in other jurisdictions.[173]

Queensland Treasury explained Victoria's proposed levy:

> The levy is a surcharge that is placed on payroll tax. The government of Victoria announced that that levy would be a surcharge paid by businesses with national payrolls over $10 million. Payroll tax is calculated by looking at the business's national payroll and then they pay that payroll on top of the employees engaged in Victoria. They have applied this surcharge to those businesses with national payrolls over $10 million. Then they apply an additional component to those businesses with national payrolls over $100 million. For a business below that $100 million threshold, they just pay the 0.5 per cent on top of their payroll. For those businesses with national payrolls over $100 million, they pay an additional 0.5 per cent on top of that.[174]

When responding to questions as to whether the Productivity Commission had considered such funding mechanisms, Productivity Commissioner, Dr Stephen King stated:

> We did not go down that route or even into that specific detail. Really, it is for the state and federal governments to coordinate and lead to be able to make sure that it is clear who is paying for what and

169 Royal Commission into Victoria's Mental Health System, *Interim Report*, November 2019, p 549.

170 Royal Commission into Victoria's Mental Health System, *Interim Report*, November 2019, p 543.

171 Royal Commission into Victoria's Mental Health System, *Interim Report*, November 2019, p 543.

172 Royal Commission into Victoria's Mental Health System, *Interim Report,* November 2019, p 544.

173 Public briefing transcript, Brisbane, 17 February 2022, p 4.

174 Public briefing transcript, Brisbane, 17 February 2022, p 4.

> who is responsible for what. Unfortunately, there did appear to be some reluctance, if I can put it that way, sometimes to take that responsibility at certain levels of government.[175]

4.4.4.1 Efficiency and accountability of funding

When considering future investment requirements, the Royal Commission also considered efficiency and effectiveness of investment. The Interim Report notes that during hearings the Royal Commission was advised:

> Funding reform is critical. If the government is to invest in reform of the mental health system, it needs to be buying something better.
>
> We should have a much stronger focus on the outcomes that are being achieved for the dollars that are being spent, not just on the activity, and in particular the outcomes that matter to the people who seek our assistance.[176]

Former Queensland Mental Health Commissioner, Dr Lesley van Schoubroeck submitted that 'people expect the annual budget process and Estimates committee hearings to shine a light on how government money is allocated and how it is spent'. Dr van Schoubroeck added:

> However, under existing budget and reporting processes in Queensland, the Health Department reports what it allocates to Hospital and Health Services for Mental Health (ie State expenditure), but those same Hospital and Health Services are not required to report what they spent on mental health services.[177]

Dr van Schoubroeck provided the following example:

> For example, North Metro Annual Report 2020/21 (p28) shows $3.380 billion revenue in total and how it was expended ... I understand that the move to reporting on Outcomes though laudable in many ways has meant that without a special Treasurer's Instruction, a Health Service can have revenue of say $338million (if mental health is 10% of total revenue) and not be required to account to the Parliament or the public as to whether or not that money was spent for the purpose for which it was allocated.
>
> Until the Government can be clear in a systemic transparent auditable way what it spends on mental health, it is difficult to consider investment – not that more money is not always welcome.[178]

The AMAQ recommended a new governance system for Queensland's funding model. The AMAQ stated:

> At present there is a lack of accountability and sufficient monitoring of resources and resource allocation and utilisation. We recommend this role be transferred to the Mental Health Commissioner as the current system is clearly not functional or transparent.[179]

Committee comment

The committee notes that Queensland's expenditure on mental health services has been lower than the national average for a decade, and in 2019-20 was the lowest per capita expenditure on mental health services in Australia.[180] It is evident that to reform Queensland's mental health and AOD system, a substantial increase in investment is required.

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175 Public briefing transcript, Brisbane, 17 February 2022, p 33.

176 Royal Commission into Victoria's Mental Health System, *Interim* Report, November 2019, p 548. NB: in-text referencing removed. Refer to original source for more information.

177 Submission 14, p 3.

178 Submission 14, pp 3-4.

179 Public hearing transcript, Brisbane, 17 February 2022, p 9.

180 Queensland Health, submission 150, p 17; Queensland Health, briefing paper, 1 February 2022, p 30; Queensland Mental Health Commission, briefing paper, 20 January 2022 p 12.

The committee notes the different funding models and mechanisms raised by stakeholders. The committee considers that creating a dedicated funding stream represents an ongoing commitment to address Queensland's underinvestment in mental health.

The committee considers that expenditure on mental health services should be transparent, and that service providers should be accountable for the delivery of agreed mental health services.

The committee also notes the impact of inconsistent funding on service delivery and the need for consistent funding to forecast workforce and service delivery needs. The committee understands that inconsistent funding impacts the ability of services to attract and retain skilled mental health and alcohol and other drug staff, as discussed in section 7.3 of this report.

Recommendation 1 – Fund and implement accountability reforms for the Queensland mental health and alcohol and other drugs service system

The committee recommends the Queensland Government:

a) increases funding and expenditure for mental health and alcohol and other drugs services in Queensland.

b) creates a dedicated funding stream for mental health and alcohol and other drug services and explores all options to create it.

c) investigates and implements accountability mechanisms to ensure service providers are delivering agreed mental health and alcohol and other drugs services, including reporting expenditure in Hospital and Health Services annual reports.

Recommendation 2 – Fund consistency and service evaluation

The committee recommends the Queensland Government:

a) applies 5-year funding cycles to state-funded mental health and alcohol and other drug services.

b) sets measurable goals for state-funded programs to assist in service evaluation for funding purposes.

5 Opportunities to improve mental health outcomes for Queenslanders

The committee heard throughout the inquiry of the opportunities to improve mental health outcomes for Queenslanders from the perspective of people with lived experience, their families and carers.[181]

The first part of this chapter considers the prevalence of mental ill-health in Queensland and the social and economic impacts. The second part of this chapter considers the voices of people with lived experience and their experience of stigma before identifying the needs of populations at greater risk of mental ill-health in Queensland.

5.1 The prevalence of mental ill-health in Queensland

Almost 1 in 2 Queenslanders experience a mental illness in their lifetime.[182] In any 12 month period in Queensland, approximately 20% of adults and 14% of children and young people experience a mental illness.[183] As noted in sections 5.3 and 5.5, a person's mental health is affected by multiple socioeconomic factors, including access to housing and other services and employment status, and impacts not only individuals but their families and carers.[184]

Mental illnesses can be grouped based on their symptoms and the effect they have on people's lives. The list below shows the percentage of Australian adults affected by certain types of mental illnesses:

- mood disorders (eg depression and bipolar disorder) – 6%
- anxiety disorders (eg agoraphobia and post-traumatic stress disorder) – up to 14%
- psychotic disorders (eg schizophrenia) – 0.5%
- eating disorders (eg anorexia nervosa and bulimia nervosa) – 1%
- personality disorders (eg borderline personality disorder and obsessive-compulsive personality disorder) – 7%
- substance use disorders (a group of conditions in which the use of substances (eg alcohol or drugs) lead to significant impairment) – 5%
- childhood behavioural disorders (eg attention-deficit hyperactivity disorder and oppositional defiant disorder) – 2% of children and adolescents.[185]

It is estimated that the distribution of mental health/illness across Queensland's population of 5.2 million comprises:

- mild mental illness – 0.47 million (9%)
- moderate mental illness – 0.26 million (5%)
- severe mental illness – 0.16 million (3%)
- at risk of developing a mental illness due to individual, social, economic and/or environmental vulnerabilities or stressors – 1.2 million (23%)

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181 See, for example, submissions 15, 19, 23 and 30.

182 Queensland Mental Health Commission, briefing paper, 20 January 2022, p 5, citing Slade, T, Johnston, A, Teesson, M, Whiteford, H, Burgess, P, Pirkis, J, Saw, S 2009, *The Mental Health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing*, Department of Health and Ageing, Canberra. See also Queensland Health, briefing paper, 1 February 2022, p 5.

183 Queensland Mental Health Commission, briefing paper, 20 January 2022, p 5.

184 Australian Institute of Health and Welfare, *Mental Health Services in Australia*, web report, 1 February 2022.

185 Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, pp 119-122; see Figure 3.1 in original source.

- well – 3.1 million (60%).[186]

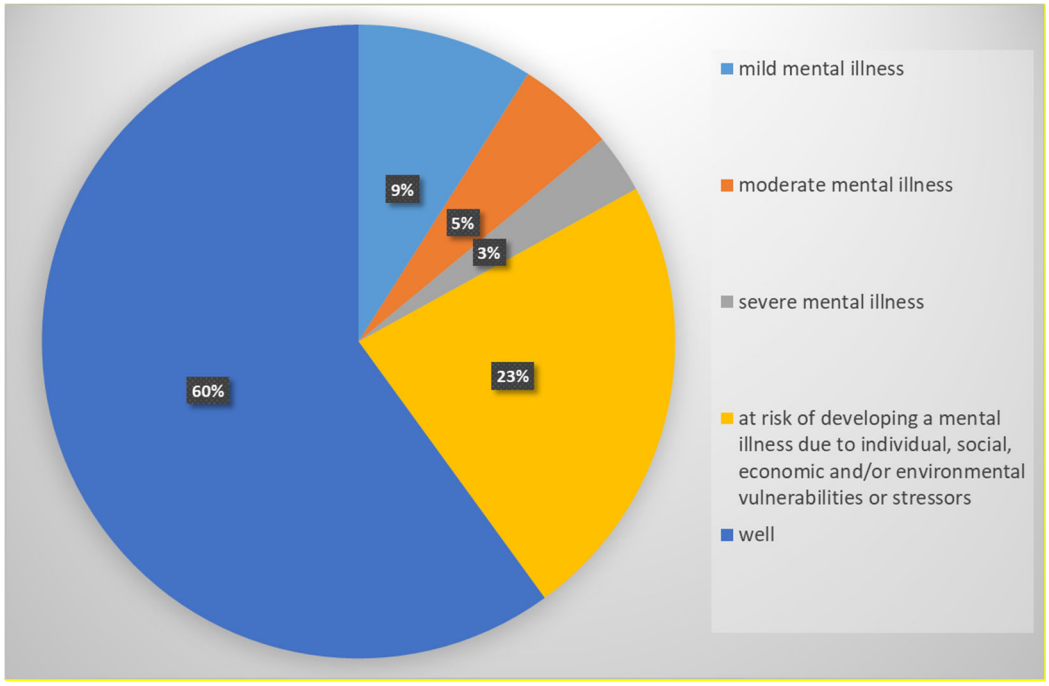

Figure 3 –Prevalence of mental ill-health in Queensland[187]

5.1.1 Suicide and suicidality

The QMHC advised that 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 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.[188]

Suicide remains the leading cause of death for Australians aged 15 to 44 years, with regional communities reporting a 54% higher rate of suicide than capital cities. Suicide rates tend to increase with remoteness, with suicide rates in very remote regions reported to be almost twice that of the national average.[189]

While mental disorders are known to increase the risk of chronic disease and premature death from suicide, 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.[190]

5.2 Economic and societal impacts of mental illness in Queensland

Mental health determines people's capacity to lead fulfilling lives — to develop and use their skills and talents, work productively and fruitfully, maintain a secure place to live, cope with the normal stresses of life, and have strong and supportive social connections. A person with mental ill-health may be

[186] Calculated using the figures in Queensland Mental Health Commission, briefing paper, 20 January 2022, p 5, Figure 2. See also Queensland Health, briefing paper, 1 February 2022, p 5.

[187] Calculated using the figures in Queensland Mental Health Commission, briefing paper, 20 January 2022, p 5, Figure 2. See also Queensland Health, briefing paper, 1 February 2022, p 5.

[188] Submission 151, p 32.

[189] Submission 151, p 32.

[190] Submission 151, p 32. NB: in-text referencing removed. Refer to original source for more information.

unable to achieve some, or all, of these important elements of life. This results in lost opportunities and costs.[191]

People living with mental illness are likely to be negatively impacted in numerous ways including:

> … 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.[192]

The Productivity Commission identified costs of mental ill-health to the community as including:

- resources expended on human services
  - healthcare (expenditure on diagnosis, treatment and recovery)
  - other services and supports (expenditure on education, employment, housing, justice and social services)
  - informal care (time and effort provided by family and friends to support individuals)
- reduction in incomes and living standards
  - lower economic participation (individuals and carers spend less time working or in education)
  - lost productivity (absent from work, or less productive while at work)
- social and emotional costs
  - pain and suffering (diminished health and premature death)
  - stigma (reluctance to seek treatment, discrimination and social exclusion)
  - lower social participation (less contact with family and friends, reduced community involvement).[193]

The Productivity Commission estimated the cost of mental ill-health and suicide in Australia is around $200 billion to $220 billion per year, including direct economic costs for 2018-19 of between $43 billion to $70 billion.[194] These direct economic costs comprised:

- the direct cost of healthcare expenditure and other services and supports – $16 billion
- the cost of lost productivity due to lower employment, absenteeism and presenteeism – from $12 billion to $39 billion
- the informal care provided by family and friends – $15 billion.[195]

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191 Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 150.

192 Queensland Mental Health Commission, briefing paper, 20 January 2022, p 9.

193 Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 151. The Productivity Commission advised that '[i]ncome support payments (such as the Disability Support Pension and carer payments) are not included because they are a transfer between different members of the community, rather than a cost to the community as a whole'.

194 Suicide Prevention Australia, submission 25, p 5, citing Stephen King, 'A brief overview of the Mental Health Inquiry Report', speech, https://www.pc.gov.au/news-media/speeches/mental-health.

195 Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 153. See also Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 155, Table 3.1 – Estimated cost of mental ill-health and suicide 2018-19.

There are also social and emotional costs. The Productivity Commission advised:

> The cost of diminished health and reduced life expectancy for those with mental ill-health, self-inflicted injury and death by suicide total approximately $151 billion. About 80% is attributable to mental illnesses ($122 billion) and the remainder attributable to death by suicide ($29 billion).
>
> The social and emotional costs of lower social participation or stigma associated with mental ill-health are not quantified ... These emotional costs may include people's feelings of self-doubt, hopelessness and a sense of isolation. These costs are difficult to value in monetary terms and consequently, we have not estimated them.[196]

In relation to the direct economic costs of up to $70 billion estimated in the Productivity Commission report, Queensland Treasury advised:

> Queensland's share of that would be roughly $14 billion a year, including $8 billion in lower economic participation and lost productivity. In addition the estimated annual social cost—the emotional cost of disability and premature death to mental illness, suicide and self-inflicted injury—nationally was equivalent to a further $151 billion. Queensland's share of this would be approximately $30 billion.[197]

In 2020-21, Queensland Health spent an estimated $1.35 billion on mental health and $139 million on AOD services.[198] Most of the money spent on mental health ($1.2 billion) was on treatment delivered through the HHSs.[199] Just over 60% of the money spent on AOD services was spent on treatment delivered through the HHSs.[200]

5.3 Comorbidity and social determinants of health

Research shows mental health and physical health are inextricably linked and that people experiencing mental illness are more likely to develop physical illness and tend to die earlier than the general population.[201] People with comorbid mental and physical ill-health also consume more health resources than those with only one disorder.[202]

Combordity is defined as:

> … the presence of two or more health conditions existing simultaneously in a person at a point in time. Comorbidity may involve more than one mental illness, which may be, for example, a substance use disorder, or a mental illness and one or more physical conditions.[203]

The pathways causing comorbidity are complex and bidirectional. Mental ill-health can lead to poor physical health and substance misuse, and vice versa.[204]

The AIHW found that evidence supports the close relationship between people's health, living and working conditions which form their social environment. Factors such as socioeconomic position, conditions of employment, power and social support — known collectively as the social determinants

196 Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 153.

197 Public hearing transcript, Brisbane, 17 February 2022, p 3.

198 Queensland Health, briefing paper, 1 February 2022, p 15.

199 Queensland Health, briefing paper, 1 February 2022, p 16.

200 Queensland Health, briefing paper, 1 February 2022, p 16.

201 Australian Institute of Health and Welfare, *Australia's health 2020: Physical health of people with mental illness snapshot*, 23 July 2020.

202 Australian Institute of Health and Welfare, *Comorbidity of mental disorders and physical conditions 2007*, 10 February 2022, p vi.

203 Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 122.

204 Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 621.

of health — act together to strengthen or undermine the health of individuals and communities.[205] Local, national and international crises can also increase risk of mental illness among vulnerable populations.[206]

In this regard, some people are more prone to mental ill-health than others due to exposure to environmental, community and family factors that are beyond any individual's control; and in some cases, exposure to multiple factors can compound the risk of mental ill-health.[207]

Evidence suggests that people experiencing mental illness are also more likely to develop physical illness due to system-level factors such as social stigma, lack of health service integration, and a lack of clarity about who is responsible for physical health monitoring in people living with a mental illness. Medication side effects — for example, weight gain and hyperlipidaemia (ie elevated levels of lipids in the blood) — may also be a significant contributor to poorer physical health for some individuals.[208]

A recent survey conducted by Lived Experience Australia (LEA) in partnership with Equally Well found:

> While mental health providers appear to ask about some physical health needs such as sleep, exercise and physical activity, other physical health needs such as smoking, drug and alcohol use, cancer screenings, etc., are often not discussed, even though there is the likelihood of approximately half of consumers being smokers and at risk.[209]

The Productivity Commission found that many people with physical comorbidities do not receive effective and integrated treatment for both their physical and mental ill-health; and that there is significant scope for governments to improve care for people with mental and physical health comorbidities.[210]

5.4 Queenslanders with lived experience of mental ill-health

The Productivity Commission report pointed to system reform that puts people at the centre of mental health service delivery, and that governments need to include the perspectives of people with a lived experience of mental illness and their carers in policy development and planning activities.[211]

The committee heard from people with lived experience throughout the inquiry whether they appeared in a personal or professional capacity, or as a lived experience (peer) worker or advocate.[212]

The experiences and leadership of people with lived experience of mental illness, problematic substance use and suicidality and their families and carers are critical to understanding what is needed to improve mental health and AOD services, reduce negative community attitudes, and promote a better quality of life.[213]

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205 Australian Institute of Health and Welfare, *Australia's health 2020: Social determinants of health snapshot*, 23 July 2020; Benjamin Druss & Elizabeth Walker, *Mental disorders and medical comorbidity*, Research Synthesis Report No. 21, February 2011, p 6.

206 Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 91.

207 Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 91.

208 Australian Institute of Health and Welfare, *Australia's health 2020: Physical health of people with mental illness snapshot*, 23 July 2020.

209 Submission 12, pp 4-5.

210 Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 653.

211 Queensland Health, submission 150, p 12.

212 See, for example, submissions 23, 32 and 45; public hearing transcript, Brisbane, 29 April 2022, p 24; public hearing transcript, Kingaroy, 20 April 2022, p 14.

213 Queensland Health, submission 150, p 12.

The committee's first public hearing and site visit was at Stepping Stone Clubhouse on 27 January 2022 to speak with people about their lived experience of mental ill-health.

5.4.1 Voices of people with lived experience

The committee received a number of submissions and heard firsthand accounts of peoples' lived experience of mental ill-health.[214]

5.4.1.1 Firsthand accounts of mental ill-health

Ms Haylene Grogan, a Yalanji and Tagalaka woman[215], described the challenges facing Aboriginal and Torres Strait Islander peoples as a result of Australia's colonial history and the intergenerational trauma this has caused:

> We First Nations people experience and confront all the same challenges, complexities and difficulties that every other Queenslander faces, whether related to family, work, health, relationships, financial security or global pandemics as we are currently experiencing. Life is challenging for all of us whether we are black, brown or white. However we, the First Nations people of these lands and the many nations we cover, also experience challenges, complexities and difficulties from our colonial history and the ongoing trauma that this has had on our families, our extended kin, our communities and our connections to culture, country and each other. Every day experiences are compounded by this additional layer until we heal, which is a process that is ongoing. It is the impact of racism and discrimination on two distinct and proud cultures, Aboriginal peoples and Torres Strait Islanders.[216]

The committee heard from Mr Shane Hicks about his experience of a diagnosis of schizophrenia as a young man:

> I was first diagnosed with schizophrenia in 2000 at the age of 24, and leading up to this time I had worked as a professional structural engineer for 4 years, had some good friends and was living independently paying off a house and had no thoughts that mental illness would ever have any negative impact on my life! This mental illness I first experienced in 2000 did not go away and over the next 5 years there was

[214] See, for example, submissions 23, 32 and 45; public hearing transcript, Brisbane, 29 April 2022, p 24; public hearing transcript, Kingaroy, 20 April 2022, p 14.

[215] Also appearing in her capacity as Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General, Aboriginal and Torres Strait Islander Health Division, Queensland Health.

[216] Public hearing transcript, Brisbane, 11 February 2022, pp 33-34.

> ongoing trial and error of medications, therapies and I could not do paid work, leading to me needing to move back in with my parents and go on government welfare payments, therefore leading to significant depression and anxiety, total isolation from society, loss of independence, hospitalisations and even a suicide attempt in late 2001. The only shining light in this very dark period was making contact with a mental health organisation called Stepping Stone at Coorparoo, where I became a member in 2003 and very slowly started to put the pieces of my life back together.[217]

Ms Laura Lewis told the committee about her experience of postnatal depression:

> My first exposure to mental illness was when I was diagnosed with postnatal depression. My firstborn was six months old and we were living in Mackay. I felt something was off and I felt incredibly guilty that my perfect baby was not making me happy. I was feeling feelings that I did not understand. I actually flew back to Brisbane to see a GP I had been seeing for years because I trusted him. I saw him once—just one appointment—and all I received was a prescription for an antidepressant. He did not discuss with me any kinds of options that could include mindfulness or seeing a psychologist. I did not know at the time that that should have been a suggestion or a conversation that was had.[218]

Mr Darryl Nelson submitted to the committee his experiences of forced adoption in Queensland in 1964 and the impact this has had on his life, including a complex psychological diagnosis including experiences of depression, complex post-traumatic stress disorder, complicated grief, suicidal ideation and comorbid physical health conditions.[219]

Mr Nelson added:

> I also had childhood trauma in my adoptive family, including physical and sexual abuse. After my adoption, my circumstances and health in my adoptive family went unmonitored by the Queensland state, which was contrary to law that expresses my 'best interests' would be served by the adoption.
>
> I was not informed by government I was adopted, and it was left to me to uncover this, which I did when I was around 14 years old during puberty, which had considerable negative impact on me. I then was denied access to my birth information by Queensland Government until I was 30 years old, when laws changed and allowed me identifying information.[220]

Committee comment

The committee acknowledges the voices of persons with lived experience of mental ill-health, suicidality and AOD issues shared throughout this inquiry. The committee commends all stakeholders who have shared their personal stories for their bravery and courage, and thanks them for their contribution to the inquiry process.

It is evident to the committee that lived experience is prevalent in the Queensland community, whether this is a firsthand experience or in the role of a carer supporting family or friends who are experiencing mental ill-health.

The committee acknowledges the role to be played by people with lived experience in mental health system reforms and advocates for the inclusion of lived experience voices in mental health and AOD policy and service delivery.

See section 7.4.5 for further information and recommendations about developing the lived experience (peer) workforce.

[217] Submission 32, p 2.

[218] Public hearing transcript, Brisbane, 29 April 2022, p 24.

[219] Submission 23, p 1.

[220] Submission 23, p 1.

5.4.1.2 Families and carers

The committee also heard of the lived experience of family members and carers of people experiencing mental health or suicidality.

The term 'carer' is commonly used to describe people who provide support to individuals who need assistance. A carer may be primarily the person's partner, parent, grandparent, neighbour, friend or, in some cases, their child or children.[221]

When in Kingaroy, the committee met with Mr Damien Martoo, President of the Kingaroy Chamber of Commerce, who shared the impact of suicide on his community and also on his family following the loss of his son Jack:

> The Kingaroy Chamber of Commerce & Industry has been going deeply into mental wellbeing and mental health services within the region over the last 12 months through direct impacts to our chamber through people who have suicided. I myself personally lost my own son just before Christmas to suicide. This is a really important opportunity for the state government to see the impact mental health is having on not just the community but the business community as well and the flow-on effects into people's personal lives. It just does not stop immediately after you lose your child. This is a forever issue now not only for me but for my business community and my entire family.[222]

Ms Bronwen Edwards, Chief Executive Officer of Roses in the Ocean, shared her lived experience of losing her brother to suicide:

> The people who are caring for people in crisis are the mums and dads who are literally getting up three times during the night to check if their children are still alive. They are the people who live that experience constantly. Every phone call that comes in might mean that their brother has taken his life.
>
> I have been in that position. I lived with those phone calls from my brother for many, many years before we lost him. … The incredible stress that comes into a family unit when you are trying desperately to keep somebody alive is enormous and impacts every part of your life.[223]

Queensland Family and Child Commission (QFCC) Youth Advocate, Ms Grace Sholl, described having to care for her parents during their experience of mental illness:

> I am the daughter of veteran parents, both of whom have a history of mental illness and suicidality. At times I have had to act as an informal carer for them. My grandparents on both sides also have a history of mental illness, with my grandfather having suicided when my dad was a toddler. I have lived with depression and anxiety since childhood myself and I am also a survivor of suicide.[224]

One submitter reflected on the impact of his role as a carer for his son who has experienced mental illness and suicidality:

> I am making this submission in my capacity as a Father of a teenager son with mental health issues. My son became involved in the public Mental Health system from the age of 11, around the time of his first attempted suicide by Ritalin and Panadol overdose (he is now 16). There is trauma I've experienced as I've watched my son decline into a world of suicidality, overdoses, illegal drugs, relationship breakdown and violence. But equally there is trauma I've experienced from dealing with a system that has not been able to effectively respond to my son (or our family) as I've followed all the correct processes to "get help".[225]

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221 Arafmi Ltd and Carers Queensland, submission 101, p 3.

222 Public hearing transcript, Kingaroy, 20 April 2022, p 14.

223 Public hearing transcript, Brisbane, 18 February 2022, p 4.

224 Published in camera hearing transcript, Brisbane, 11 February 2022, p 2.

225 Name withheld, submission 72, p 1.

5.4.1.3 Inclusion of families and carers in healthcare settings

Carers Queensland advised that:

> This year 533,200 Queenslanders, including children and young people, will provide 357.4 million hours worth of unpaid care and support to a family member or friend, the replacement value of which has been conservatively estimated at $16.51 billion. Our contribution to the humanity of our society is real and the contribution to Queensland's health and social care economies is tangible.[226]

Carers may live with the person they are caring for or visit the person regularly. They can provide a range of supports including emotional and social support throughout the day and assistance with practical tasks and daily living.[227]

Carers are people who invest variable levels of time, energy, and support, generally in an unpaid capacity. Carers are often 'hidden', may not see themselves as a carer and/or are not identified and supported by services and communities.[228]

Carers Queensland advised the committee that carers continue to feel excluded from decision-making processes related to the person they are caring for:

> Carers continue to tell us that they feel marginalised, disregarded or locked out of the decision-making processes, particularly in those situations where they have challenged the decision of the treating teams or where they have been deemed to be the source of the problem by the treating team. Yet these same carers tell us that it is assumed by those treating practitioners that they will continue to provide support, having never been consulted about their capacity or willingness to provide care on an ongoing basis or any inquiry about their safety.
>
> The hesitancy of mental health practitioners to see and respect carers as genuine partners in the care process, people with extraordinary skill and knowledge and a genuine want to work in partnership with those in the service, remains a concern to Carers Queensland. We ask: how can we tangibly address this persistent issue?[229]

The Royal Commission into Victoria's Mental Health System advised that there about 60,000 Victorians who care for someone living with mental illness. The Royal Commission reported that:

> Families, carers and supporters can feel excluded by the system, and are often left out of engagement that would help them in their caring role. Many families, carers and supporters require but are unable to access dedicated supports in their own right. There is a widespread lack of access to information about treatment, care and support to assist families, carers and supporters.[230]

The Royal Commission identified the role of families, carers and supports as 'central to the mental health and wellbeing system'. The Royal Commission stated:

> The value of families, carers and supporters will be promoted across the system, and family- and carer-led centres will be established to support them and respond to their needs.[231]

5.4.1.4 Including voices of lived experience in service delivery reform

Care Opinion Australia (COA) is a not-for-profit organisation that facilitates transparent, independent and two-way communication via an online public platform. COA allows consumers (patients, service

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226 Carers Queensland, public hearing transcript, Brisbane, 18 February 2022, p 5.

227 Arafmi Ltd and Carers Queensland, submission 101, p 3.

228 Arafmi Ltd and Carers Queensland, submission 101, p 3.

229 Public hearing transcript, Brisbane, 18 February 2022, p 5.

230 Royal Commission into Victoria's Mental Health System, *Summary and recommendations*, Victorian Government Printer, February 2021, p 11.

231 Royal Commission into Victoria's Mental Health System, *Summary and recommendations*, Victorian Government Printer, February 2021, p 25.

users, clients, carers, family members) to share holistic stories (accounts) of their experiences with health, aged and social care service providers without reserve or the confines of survey boxes.[232]

COA reported that these accounts of lived experience are being told in order to 'to recognise the exceptional care that was received and/or to highlight the need for change'. COA added:

> COA is committed to supporting subscribers to achieve their mission of facilitating connection and conversations between consumers and service providers. COA enables people to share their experiences of health and care in ways which are safe, simple and leads to change. COA moderates each story to ensure anonymity is maintained, services are protected, and consumers remain safe through the two-way dialogue in the public domain. Anonymity is particularly crucial, in terms of safety, for those at risk of, or experiencing, mental health concerns.[233]

COA recommended that Queensland Health adopts a transparent, system-wide, online public feedback and response mechanism, such as the COA model. This consumer-led platform will enable services to directly hear of the lived experience from service users, their families and carers, and equip services with the ability to individually investigate and respond to the needs of those at greater risk of mental ill-health. COA stated that this feedback could be used to guide consumer-centric service reform that leads to better outcomes and workplace improvements.[234]

Committee comment

The committee acknowledges the lived experience of mental ill-health shared by family members and carers of people experiencing mental ill-health or suicidality, and the impact that caring for a family member or loved one can have on a carer's health and wellbeing. The committee notes the many sacrifices stakeholders have described in their care for someone experiencing mental ill-health, suicidality or substance misuse.

The committee notes the need to engage with families, carers and supporters in providing mental health and AOD services in Queensland.

The committee has also heard of the opportunity to incorporate voices of lived experience in consumer-centric service reforms, facilitated by an anonymised feedback mechanism managed by a third party, such as the model used by Care Opinion Australia.

Recommendation 3 – Include families, carers and support persons in Queensland's mental health system

The committee recommends the Queensland Government investigates and implements strategies to better involve families, carers and support persons in the mental health care and treatment of individuals.

Recommendation 4 – Include voices of lived experience in service delivery reform

The committee recommends the Queensland Government evaluates Care Opinion Australia's consumer feedback model for implementation in Queensland, or other alternatives that incorporate independent consumer feedback.

5.4.2 Stigma

Stigma and discrimination are often nominated as central concerns for people with mental health issues and are significant barriers to help-seeking and inclusion. Stigma and discrimination can adversely affect wellbeing in a number of ways, including worsening psychological distress, inhibiting

232 Submission 53, p 2.

233 Submission 53, p 2.

234 Submission 53, p 2.

help-seeking and treatment adherence, limiting personal relationships, and reduced ability to achieve educational and vocational goals.[235]

Stigma is experienced across a range of settings, including healthcare, justice and welfare systems, friends, families and communities, and creates barriers to seeking treatment, accessing employment, housing and community belonging.[236]

The committee heard from a range of stakeholders who reported feeling stigmatised when experiencing a period of mental ill-health.[237]

5.4.2.1 Stigma and discrimination by health professionals

The Productivity Commission stated that its inquiry participants with mental illness reported experiencing stigma and discrimination in their interactions with the health sector. Research cited by the Productivity Commission report highlighted that the most common perceived experiences of discrimination included health professionals treating people with mental illness dismissively or disbelieving them, judging them or being unwilling to listen.[238]

Queensland Health advised that stigma by health professionals toward people with mental illness including problematic substance use is associated with poorer physical health outcomes as physical conditions are often overlooked, not recognised or attributed to aspects of one's pre-existing illness or problematic substance use.[239]

Sadly, stakeholders shared experiences of stigma and discrimination by health professionals in Queensland. For example, QFCC Youth Advocate Ms Grace Sholl told the committee:

> My experience in hospital after my suicide attempt did not heal me. The trauma I experienced was worse than that of my suicide attempt. I was ignored, I was belittled, I was exposed inappropriately and I was given the advice that I could treat my eating disorder with Jenny Craig. I was released after 10 hours with no support and no checks to ensure I was safe to go home. … Hospitalisation only hindered my mental health. My family and I are continuing to pay the price for trying to do the right thing and call for help, just as most mental health organisations suggest when someone is feeling unsafe.[240]

The committee also heard from Ms Mia Pattison who described instances of stigma she has been subject to from health professionals, often in the emergency department, as a result of her borderline personality disorder. She noted a study shows that many people with mental ill-health have stopped themselves from calling '000' for an ambulance or going to hospital for emergency mental healthcare because of stigma about mental health issues.[241]

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235 Groot, C, Rehm, I, Andrews, C, Hobern, B, Morgan, R, Green, H, Sweeney, L, and Blanchard, M (2020). *Report on Findings from the Our Turn to Speak Survey: Understanding the impact of stigma and discrimination on people living with complex mental health issues,* https://nationalstigmareportcard.com.au/sites/default/files/2021-06/NSRC_Full_Report.pdf. Anne Deveson Research Centre, SANE Australia. Melbourne, p 25.

236 Queensland Health, Submission 150, p 26.

237 See, for example, submissions 159, 23 and 32; Published in camera hearing transcript, Brisbane, 11 February 2022, p 2.

238 Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 742; see original source for research conducted by Morgan et al (2016).

239 Submission 150, p 26.

240 Published in camera hearing transcript, Brisbane, 11 February 2022, p 2.

241 Submission 159, p 6. See C Groot, I Rehm, C Andrews, B Hobern, R Morgan, H Green, L Sweeney and M Blanchard, *Report on Findings from the Our Turn to Speak Survey: Understanding the impact of stigma and discrimination on people living with complex mental health issues*, 2020, Anne Deveson Research Centre and SANE Australia, pp 161, 167.

Ms Pattison recommended further training for all health professionals who encounter mental health patients, such as in unconscious bias and in responding to mental health disorders and crises, to improve treatment in emergency departments.[242]

5.4.2.2 Alcohol and other drugs

Facing stigma and discrimination is common for people who use drugs in Queensland, and this has created barriers to seeking help, compounds social disadvantage, contributes to social isolation, and negatively impacts a person's mental and physical health.[243]

QNADA advised:

> Hearing the voices of people who use drugs in Queensland is incredibly difficult because of the stigma and discrimination that they experience and fear of disclosure. There is a whole raft of issues that make hearing those voices incredibly difficult.[244]

According to Queensland Injectors Voice for Advocacy and Action (QuIVAA), unhelpful and outdated system responses and philosophies can perpetuate stigma and discrimination.[245]

The committee heard how the stigma associated with some AOD services discourages health practitioners from offering particular harm reduction services. For example, QuIVAA described the stigma associated with opioid treatment prescribers:

> There are huge amounts of stigma. We are not seeing doctors wanting to become opioid treatment prescribers in the numbers that we need them to, so doctors who are opioid treatment prescribers are often overwhelmed, their appointments fill up really quickly and they are often unable to provide holistic care for people because they are just so busy.[246]

5.4.2.3 Stigma and help-seeking

According to DVConnect, both domestic and family violence and mental illness have historically been subject to stigma and discrimination. Individuals impacted by both may have also experienced shame, feelings of worthlessness, blame and hopelessness. These perceptions and feelings are often self-perpetuating and can damage how they engage with services, as well as how they are responded to.[247]

The QFCC reported that stigma within families around mental health was cited as a barrier, as well as fear of parents finding out their child had accessed services without their consent. [248]

A 17-year-old woman reported to the QFCC:

> Several of my friends have signs of depression and anxiety and have tried to ask for help from their parents to take them to a psychologist but they refuse to and say it is not real and it's just a phase. Even if it is a phase WE NEED HELP at this point in time so listen to us and please help![249]

5.4.2.4 Stigma reduction

The committee acknowledges that work is already occurring in some sectors to destigmatise mental ill-health and encourage help-seeking behaviours.[250]

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242 Submission 159, p 6.

243 Queensland Injectors Voice for Advocacy and Action, submission 75, p 3.

244 Public hearing transcript, Brisbane, 16 February 2022, p 3.

245 QuIVAA, submission 75, p 3.

246 Public hearing transcript, Brisbane, 13 April 2022, p 7.

247 Submission 85, p 8.

248 QFCC, submission 128, p 12.

249 QFCC, submission 128, p 12.

250 See, for example, public hearing transcript, Brisbane, 12 April 2022, pp 3-8.

batyr Australia Limited, a preventative education mental health organisation driven by young people for young people, reported that 'research into the most effective ways of reducing stigma indicates that hearing stories of lived experience from a relatable, credible peer has a powerful impact on stigmatised attitudes'.[251]

For example, the committee heard of Queensland Police Service work to support the mental health and wellbeing of its staff and encourage conversations about lived experience of mental ill-health amongst colleagues:

> In terms of the stigma around mental health, we work on that every day. Some of the things that we are doing now under the Our People Matter strategy include the local champions in each particular district. They can sometimes be junior officers or, more importantly, senior officers who will go and talk about their lived experience with mental health. When they have the openness and willingness to stand there and share amongst their peers about situations or episodes that they have encountered and how they have had to deal with that, it brings that lived experience and the fact that people do not feel isolated anymore; they feel they can reach out. Part of the strategy, very importantly, is the ability to connect people at different levels, whether it is a peer support officer just for support or a range of referral options to professional people.[252]

The QPS also advised of the mental health awareness training it undertakes to educate new officers about interacting with someone who may be experiencing an episode of mental ill-health or crisis:

> At the first year level officers receive ongoing training. It is face-to-face eight-hour training. This is meant to cement the learnings of the first year officer about mental illness, its prevalence, the appropriate language to use when dealing with those jobs, understanding the stigma involved with that sort of health condition, managing the legislation, and how to respond to those crisis situations. There are additional workplace activities first year constables are also involved in, and there are also additional courses the QPS offers to those who are interested and involved in those types of calls for service.[253]

Queensland Health advised of its stigma reduction campaign *Shatter the Stigma* led by mental health and AOD services:

> HHSs have taken on the Shatter the Stigma campaign following its development by Mackay HHS. This campaign takes many forms across the state, including promotion of stigma reduction by wearing a Shatter the Stigma shirt on an identified day and conducting awareness raising activities within the HHS and wider community. Wide Bay HHS has extended its program into an ongoing campaign aimed at reducing stigma. This includes staff training and awareness raising and Shatter the Stigma ambassadors across the HHS to promote stigma reduction and work toward change.[254]

To address stigma, Suicide Prevention Australia recommended delivering a:

> Stigma Reduction Strategy that actively targets the stigma and discrimination directed towards people with mental illness, and that builds upon Queensland's Suicide Prevention Strategy and Queensland's Mental Health, Alcohol and Other Drugs Strategic Plan. The Strategy should be targeted and measurable.[255]

Committee comment

The committee heard evidence that the stigma associated with mental ill-health can worsen psychological distress and adversely impact a person's help-seeking behaviour and treatment adherence. The stigma associated with mental ill-health is not experienced in isolation but across a

[251] Submission 64, p 4.

[252] Public hearing transcript, Brisbane, 12 April 2022, p 8.

[253] Public hearing transcript, Brisbane, 12 April 2022, p 3.

[254] Submission 150, p 26.

[255] Submission 25, p 15.

range of contexts, including healthcare settings, the criminal justice system and within families and communities.

As reported by the Productivity Commission, the most common perceived experiences of discrimination include health professionals treating people with mental illness dismissively or disbelieving them, judging them or being unwilling to listen.[256]

It has also been reported that stigma by health professionals toward people experiencing mental ill-health, including problematic substance use, is associated with poorer physical health outcomes because physical conditions are overlooked, not recognised or attributed to aspects of a person's pre-existing illness or substance use behaviours.[257]

The committee heard of the prevalence of eating disorders in Queensland, particularly for young people, and of the low levels of help-seeking behaviour in this cohort (see section 6.3.4.6). The committee also heard of the strong link between low levels of help-seeking among people with eating disorders and stigma. For people with eating disorders, stigma and shame are reportedly the most frequently identified barriers for accessing treatment.[258]

The committee acknowledges that research into effective ways of reducing stigma related to mental health has shown that hearing stories of lived experience from relatable, credible peers has a powerful impact on stigmatised attitudes.[259]

It is the committee's view that destigmatising mental ill-health, alcohol and other drugs issues and eating disorders requires the voices of people with lived experience, including children and young people, and supports their involvement in the development of a public health campaign to reduce stigma and encourage help-seeking behaviours in the community.

The committee discussed with stakeholders the need to create capacity amongst the community to reach into a person's life when they are showing signs of being in crisis.[260] The committee heard that 'help-offering' can eliminate barriers to help-seeking, such as poor psychosocial education, stigma and shame.[261] The committee considered there is a need to encourage 'help-offering' behaviours in the community.

The committee acknowledges the National Mental Health Commission's *Stigma and Discrimination Reduction Strategy* which is being developed as part of the national mental health reform agenda. The strategy is being developed in partnership with people with lived experience of mental ill-health and people who have been directly affected by stigma.[262]

256 Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 742; see original source for research conducted by Morgan et al. (2016).

257 Queensland Health, submission 150, p 26.

258 Eating Disorders Queensland, submission 96, p 2.

259 batyr Australia Limited, submission 64, p 4.

260 Public hearing transcript, Brisbane, 10 March 2022, p 25.

261 MATES in Construction, submission 97, p 1.

262 National Mental Health Commission, *National Stigma and Reduction Strategy*, https://www.mentalhealthcommission.gov.au/Projects/stigma-and-discrimination-reduction-strategy.

Recommendation 5 – Public health campaign to reduce stigma

The committee recommends the Queensland Government:

a) develops and implements a public health campaign to reduce stigma associated with mental ill-health, alcohol and other drugs issues and eating disorders, which also encourages help-seeking and help-offering behaviours.

b) in conjunction with the development of a public mental health campaign, develops mental health awareness training tools and programs for use in the public, private, not-for-profit and education sectors.

c) encourages the uptake of Mental Health First Aid training.

5.5 Populations at greater risk of poor mental health

The committee was tasked with considering the mental health needs of people at greater risk of poor mental health. This section does not capture the needs of all groups that may be at an increased risk of mental ill-health, but considers themes raised consistently during the inquiry.

As noted at section 5.3, research has shown that the social determinants of health can produce greater risk of mental ill-health for some populations when compared to the broader community.[263]

The World Health Organization reported that depending on the local context, certain individuals and groups in society may be placed at a significantly higher risk of experiencing mental health problems. These vulnerable groups may, but do not necessarily, include:

- members of households living in poverty
- people with chronic health conditions
- infants and children exposed to maltreatment and neglect
- adolescents first exposed to substance use
- minority groups
- indigenous populations
- older people
- people experiencing discrimination and human rights violations
- lesbian, gay, bisexual, and transgender persons
- people involved in the criminal justice system
- people exposed to conflict, natural disasters or other humanitarian emergencies.[264]

As stated in section 2.2.3, the committee notes that defence personnel and veterans experience a greater risk of poor mental health related to their service and that this issue is currently the subject of a Royal Commission into Defence and Veteran Suicide (for more information and a committee comment on this issue see section 2.2.3).

[263] Australian Institute of Health and Welfare, *Australia's health 2020: Social determinants of health snapshot*, 23 July 2020.

[264] World Health Organization, *Comprehensive mental health action plan 2013-2030*, p 2.

The committee also notes the ongoing impact of large-scale disruptions such as the COVID-19 pandemic which has had broad, variable and changing effects on the mental health and wellbeing of Queenslanders.[265]

5.5.1 Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander peoples have experienced historical and community trauma, including the separation and isolation of children, families and communities, and this inter-generational trauma 'correlates with an increased likelihood of adverse cultural, health and socio-economic outcomes'.[266]

In terms of mental health outcomes:

- the suicide rate in Aboriginal and Torres Strait Islander peoples is twice that of non-Indigenous peoples, and suicide occurs at younger ages[267]
- intentional self-harm is the fifth highest cause of death for Aboriginal and Torres Strait Islander peoples, with males representing the majority of suicide deaths at 83%[268]
- the rates of juvenile detention and adult incarceration of Aboriginal and Torres Strait Islander peoples in Queensland are 23.6 times and 10.6 times the non-Indigenous rates, respectively[269]
- Aboriginal and Torres Strait Islander peoples experience higher rates of hospitalisation than other Queenslanders for psychoactive substance abuse, schizophrenia, and other psychotic disorders but lower rates than other Queenslanders for depression and anxiety, despite higher rates against all determinants for these disorders and levels of psychological distress[270]
- Aboriginal and Torres Strait Islander peoples experience higher rates of seclusion and restraint in hospital and higher rates of discharge against medical advice.[271]

The QFCC stated that 'the current lack of dedicated, culturally safe services across the continuum of support creates a significant challenge to ensuring that Aboriginal and Torres Strait Islander people have access to the right type of support, when and where it is required'.[272]

Aboriginal and Torres Strait Islander peoples often face additional challenges in terms of accessing mental health care services, including:

- discrimination
- lack of services available in rural, regional and remote locations and an approach that does not consider holistic wellbeing
- lack of culturally appropriate services

265 Submission 151, p 34.

266 Public hearing transcript, Brisbane, 11 February 2022, p 2.

267 Queensland Mental Health Commission, *Every life. The Queensland Suicide Prevention Plan 2019-2029, Phase One*, p 9.

268 Queensland Mental Health Commission, *Every life. The Queensland Suicide Prevention Plan 2019-2029, Phase One*, p 9.

269 Institute for Urban Indigenous Health, submission 137, p 10.

270 Institute for Urban Indigenous Health, submission 137, p 10.

271 Institute for Urban Indigenous Health, submission 137, p 10.

272 Queensland Family and Child Commission, submission 128, p 13.

- difficulty navigating the system
- a fragmented mental health system that generates significant challenges for Aboriginal and Torres Strait Islander peoples, families, communities and the community control sector
- funding is fragmented and under-resourced
- lack of approach to mental health wellbeing that centres around Indigenous frameworks, identifies, priorities, values and needs
- lack of an Aboriginal and Torres Strait Islander mental health workforce to improve access and outcomes.[273]

According to the Institute for Urban Indigenous Health (IUIH), despite the Australian and Queensland Governments' commitment under the 2009 *National Indigenous Reform Agreement* (also known as the Close the Gap Agreement), mental health has been ignored. The IUIH stated that 'there was no dedicated funding for mental health, or any mental health/addiction/suicide prevention performance indicators/targets, in this agreement'.[274]

The Queensland Aboriginal and Islander Health Council also expressed the view that all Aboriginal and Torres Strait Islander peoples, families and communities in Queensland and Australia 'deserve a mental health system that actively recognises the unique needs and values of Aboriginal and Torres Strait Islander people and provides holistic, accessible and culturally safe care regardless of location'.[275]

5.5.1.1 Improving mental health outcomes for Aboriginal and Torres Strait Islander Queenslanders

The QFCC recommended:

> The introduction of culturally grounded assessment tools and culture affirming service models should be prioritised to ensure the mental health needs of Aboriginal and Torres Strait Islander children and young people are addressed, holistically and in the context of intergenerational trauma.[276]

The IUIH made a number of recommendations to improve the responsiveness of the health system to the mental health and addiction needs of Aboriginal and Torres Strait Islander peoples in South East Queensland. For example:

- consistent with the commitments under the National Close the Gap Agreement and the recommendations of the Productivity Commission, preference Community Controlled Health Sectors as the providers of mental health, addiction, suicide prevention, aftercare, and psychosocial support services for Aboriginal and Torres Strait Islander Queenslanders, particularly in South East Queensland where there is a strong and comprehensive community controlled service system
- utilise a place-based, targeted approach to commissioning Indigenous mental health, addiction, suicide prevention, aftercare, and psychosocial support services in line with the capacity of local Community Controlled Health Sectors, noting that co-designed, Aboriginal and Torres Strait Islander led service provision is also a key domain of the Queensland Government's First Nations Health Equity agenda.[277]

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273 See, for example, Queensland Network of Alcohol and Other Drug Agencies Ltd, submission 48, p 38; Queensland Aboriginal Islander Health Council, submission 127, pp 7, 8.

274 Submission 137, p 3.

275 Submission 127, p 9.

276 Queensland Family and Child Commission, submission 128, p 4.

277 Submission 137, p 7.

The Queensland Aboriginal and Islander Health Council made the following recommendations:

- mental health funding for Aboriginal and Torres Strait Islander people and communities should be consolidated and allocated through the Aboriginal and Torres Strait Islander Community Controlled Health Organisations sector as a matter of priority
- a holistic understanding of mental health and wellbeing that centres on Aboriginal and Torres Strait Islander identity, values and needs should be embedded through the mental health system and supported with culturally safe care in all settings to drive health equity and improve outcomes
- the mental health system recognises and acknowledges the distinction between mental health and social, emotional and cultural wellbeing for Aboriginal and Torres Strait Islander peoples
- address systemic barriers that create challenges implementing local solutions and expertise and provide resources for the Aboriginal and Torres Strait Islander Community Controlled Health Organisations sector to implement consistent social and emotional wellbeing services and address local need with access to adequate workforce
- dual diagnosis should be embedded in all mental health strategy, planning and operations rather than treated separate, and apart from, mental health
- commit to addressing the significant fragmentation and lack of accountability in the mental health system and establishing a new way of working that embeds Aboriginal and Torres Strait Islander self determination.[278]

Committee comment

The committee acknowledges the intergenerational trauma caused by colonisation, as well as subsequent government policies, and the ongoing impact this has had, and continues to have, on the mental health and wellbeing of Aboriginal and Torres Strait Islander peoples, and their connection to culture, country and kin.

Aboriginal and Torres Strait Islander peoples consistently expressed to the committee the need to support initiatives that seek justice for Aboriginal and Torres Strait Islander Australians, including community-based reconciliation initiatives that respond to the issue of intergenerational trauma. For example, the Uluru Statement from the Heart, the Queensland Government's *Path to Treaty* and the *Queensland Government Reconciliation Action Plan 2018-2021*[279] administered by the Department of Seniors, Disability Services and Aboriginal and Torres Strait Islander Partnerships.

The committee supports these views.

The committee has heard throughout the inquiry of the need for greater representation of Aboriginal and Torres Strait Islander peoples in Queensland's mental health and AOD service delivery system. See section 7.6 for more information about improving representation of Aboriginal and Torres Strait Islander peoples in Queensland's mental health and AOD workforce.

5.5.2 Trauma and adverse childhood experiences

Exposure to trauma and chronic stress may also be a risk factor for both mental and physical ill-health. Trauma can have lifetime and intergenerational consequences on a person's mental wellbeing,

[278] Submission 127, p 5.

[279] The *Reconciliation Action Plan 2018-2021* was due to end on 30 June 2021. Due to the impacts of the global COVID-19 pandemic, the *Reconciliation Action Plan 2018-2021* has been extended to 31 December 2022.

regardless of the source of trauma (including childhood trauma, intergenerational trauma, exposure to violence, or trauma caused by extreme weather events or natural disasters).[280]

The issue of adverse childhood experiences and later life mental illness was raised a number of times during the inquiry.[281]

Published in 1998, the Adverse Childhood Experience (ACE) Study was the first large scale study examining the relationship between 7 categories of ACE, including:

- psychological, physical, or sexual abuse
- violence against mother
- living with household members who were substance abusers, mentally ill or suicidal, or ever imprisoned.[282]

The presence of these ACE categories was then compared to measures of adult risk behaviour, health status and disease. The ACE Study highlighted that a person who has experienced 4, or more, ACEs is:

- 12 times more likely to attempt suicide
- 10 times more likely to use intravenous drugs
- 7 times more likely to experience alcoholism
- 5 times more likely to experience depression.[283]

A number of witnesses commented on ACEs. For example, DCYJMA told the committee:

> We are very aware that children who have experienced neglect and abuse are more vulnerable to mental health concerns and that trauma can impact the emotional wellbeing of these children. Research tells us that increased adverse childhood events lead to increased health and social problems across the life span. We know that for many children subject to child protection orders they have experienced a high number of adverse childhood events which further increases their vulnerability and risk of developing adverse mental health outcomes.[284]

DCYJMA advised that it coordinates a number of whole-of-government strategies that impact on the provision of services to children and families experiencing risk. DCYJMA added:

> Supporting Families Changing Futures is the lead strategy driven by the department where the department has portfolio responsibility, and that is about that holistic approach to meeting family need and creating a service system that responds to the needs of children and families. The department then makes commitments under other whole-of-government strategies led by the Queensland Mental Health Commission and strategies led by the Department of Education that all point to a collective approach to responding to the needs of children and families. Through processes of reporting to government, the

280 Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 94.

281 See, for example, submissions 86, 111 and 128.

282 Vincent J Felitti, Robert F Anda, Dale Nordenberg, David F Williamson, Alison M Spitz, Valerie Edwards, Mary P Koss, James S Marks, Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study, American Journal of Preventive Medicine, Volume 14, Issue 4, 1998, pp 245-258.

283 Vincent J Felitti, Robert F Anda, Dale Nordenberg, David F Williamson, Alison M Spitz, Valerie Edwards, Mary P Koss, James S Marks, Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults: The Adverse Childhood Experiences (ACE) Study, American Journal of Preventive Medicine, Volume 14, Issue 4, 1998, pp 245-258.

284 Public hearing transcript, Brisbane, 11 February 2022, p 3.

> impact of the implementation of those strategies is assessed and government has the opportunity to consider whether or not there is any further need.[285]

The Queensland Mental Health Commissioner advised:

> There is urgent need for increased, sustained and tailored whole-of-government commitment and strategies at least in these areas as a starting point: early years, having the best start in life, including preventing and reducing the impact of adverse childhood experience—we can get some major gains there; children and young people, particularly in schools, in child care, in various contexts; community wellbeing; but also workplace mental health and psychological safety. Each of these areas will yield major benefits across multiple sectors, systems and the economy.[286]

5.5.2.1 Trauma-informed practice

The Royal Commission into Victoria's Mental Health System reported that there is a close relationship between trauma and mental illness. The Royal Commission stated that the need for trauma-informed mental health treatment, care and support is starting to be recognised. The system needs to provide more holistic approaches for consumers and must be responsive to trauma and the potential for consumers to be retraumatised.[287]

Stakeholders raised the need for mental health services to be delivered by people who have been trained in trauma-informed practices.[288]

According to Inala Primary Care, compelling evidence demonstrates 'past trauma significantly increases the risk of long-term mental and physical health problems, sometimes serious'.[289]

DVConnect submitted:

> A trauma-informed lens is essential for clinicians and other service providers to see beyond the presenting characteristics that may be masking trauma and risk.[290]

Accoras advised that a trauma-informed service model is critical to providing safe and effective support. Accoras stated that its services are based on the understanding that:

- the experience of trauma is far-reaching and impacts across mental, social and occupational life domains throughout the lifespan
- the way mental health organisations are structured, and the way they deliver services and supports, can impact on the recovery and wellbeing of traumatised individuals.[291]

One stakeholder advised that there 'definitely needs to be' a whole-of-government approach to trauma.[292] Women's Health & Equality Queensland stated that 'it is important that every single person who is working in the health system is trained' in a trauma-informed model, and that it should be applied in other contexts.[293]

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285 Public hearing transcript, Brisbane, 11 February 2022, p 4.

286 Public hearing transcript, Brisbane, 20 January 2022, p 25.

287 Royal Commission into Victoria's Mental Health System, *Summary and recommendations*, Victorian Government Printer, February 2021, p 12.

288 See, for example, submission 66, 85, 88 and 90.

289 Submission 90, p 3.

290 Submission 85, p 9.

291 Submission 87, 48.

292 Grace Homestead, public hearing transcript, Brisbane, 13 April 2022, p 4.

293 Public hearing transcript, Brisbane, 29 April 2022, p 3.

Committee comment

The committee acknowledges that people who have experienced trauma and/or adverse childhood experiences are at greater risk of experiencing mental ill-health. The committee has heard that trauma can impact across domains of life and across the lifespan. The committee notes that the way in which services are structured, and the way services and support are delivered, can impact on a traumatised individual's recovery and wellbeing.[294]

Recommendation 6 – Whole-of-Government Trauma Strategy

The committee recommends the Queensland Government develops a whole-of-government trauma strategy to be implemented by the Queensland Government, and that the strategy:

a) considers multidisciplinary trauma research and implements best practice strategies for responding to people that have experienced trauma, including but not limited to physical and sexual abuse, domestic and family violence and adverse childhood experiences.

b) considers how trauma-informed practice can be embedded in service provision in human services areas, including health, housing, education, corrective services and child safety.

5.5.3 Children and young people

The QFCC advised that the early years of life are critical to the development of solid foundations for lifelong mental health and wellbeing. Exposure to ACEs contributes to poor lifelong outcomes, but supporting children to have a strong start, through strong child and family support services, provides benefits to the whole community.[295]

The QMHC submitted that 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.[296]

The committee heard throughout the inquiry of a concerning increase in the experience of poorer mental health among young Queenslanders.[297]

5.5.3.1 Nature and prevalence of mental ill-health in young people

headspace advised that the incidence of mental ill-health in Australia is the highest among young people aged between 16 and 24, with one in four young people experiencing symptoms.[298]

Orygen submitted that half of all mental ill-health onset occurs before the age of 15, and three quarters occurs by the time a person is 24 years old. Mental ill-health is the leading cause of disability in young people (10 to 24 years), accounting for 45% of the overall burden of disease in this age group.[299]

Suicide is the leading cause of death among young Australians, for which mental ill-health is a risk factor. For every 100,000 young Queenslanders (15 to 24 years old), 19.2 die by suicide. This is above the national average of 14.2 for this age group, and almost doubles Victoria's rate of 10.1. [300]

294 Accoras, submission 87, p 48.

295 Submission 128, p 5. NB: in-text referencing removed. Refer to original source for more information.

296 Submission 151, p 128.

297 See, for example, submissions 66, 128, 150 and 151.

298 headspace, submission 66, p 10.

299 Submission 73, p 4. NB: in-text referencing removed. Refer to original source for more information.

300 Submission 73, p 4. NB: in-text referencing removed. Refer to original source for more information.

In Queensland between 2019-20 and 2020-21 referrals for mental health community treatment services increased by approximately 20% for adolescents aged 12 to 17 years old.[301]

When asked whether research can explain a reported global increase in mental health issues among young people, Professor Pat McGorry told the committee that while the evidence is not definitive, some factors include:

- the impact of social media
- the insecurity of life for young people now compared to 3 or 4 decades ago
- the casualisation of the workforce
- climate change.[302]

5.5.3.2 Help-seeking behaviours

According to headspace, young people's experience of mental health is unique and help-seeking behaviour by young people with mental health issues is extremely fragile. In a recent survey of young people, almost half said that if they were experiencing a personal or emotional problem, they would deal with it on their own.[303]

headspace added:

> Help-seeking behaviour is also a greater issue for young men, Aboriginal and Torres Strait Islander young people, LGBTIQA+ people, rural and remote young people, and young people from migrant and refugee backgrounds. If young people find the courage to seek help for a mental health issue and they do not have a positive experience they are highly likely not to seek help again.[304]

See section 6.3.4 for more information and recommendations about services for children and young people.

5.5.4 People living in rural, regional and remote communities

Queensland's vast geographic spread creates additional challenges for the mental health system in rural and remote areas of the state.[305] More than 17% of Queensland's population, around 817,655 people, live in rural and remote areas, encompassing many diverse locations and communities. However, investment is focused in city-based models in areas with more dense populations.[306]

While the prevalence of mental illness is similar in urban and regional Australia, the outcomes are worse for people living in rural areas. The challenges of accessing treatment and support in rural and remote areas of Queensland, particularly for people who are considering, or who may have attempted suicide, are considerable.[307]

The Productivity Commission found:

> Living in regional and remote areas carries along a set of unique risk factors for mental illness, including isolation and environmental events such as droughts and bushfires. The prevalence rate of mental illness

301 Queensland Health, public briefing transcript, Brisbane, 20 January 2022, p 2.

302 Public hearing transcript, Brisbane, 17 February 2022, pp 18-19.

303 headspace, submission 66, p 10. NB: in-text referencing removed. Refer to original source for more information.

304 headspace, submission 66, p 10. NB: in-text referencing removed. Refer to original source for more information.

305 Anglicare Southern Queensland, submission 41, p 7.

306 Wesley Medical Research & Outback futures, submission 93, p 2.

307 Wesley Medical Research & Outback futures, submission 93, p 2.

> in regional areas is similar to those in urban areas, but males in regional and remote areas experience higher levels of psychological distress than those living in major cities.
>
> A stark difference between urban and regional living becomes apparent when comparing suicide rates. The suicide rate in regional areas has been consistently higher over time compared with those in major cities, and suicide rates tend to increase with remoteness, with suicide rates in very remote regions almost twice that of the national average.[308]

The QMHC identified the following social determinants of health experienced by people living in rural and remote Queensland:

- 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
- downturns in service and business viability, including equitable access to healthcare.[309]

Anglicare Southern Queensland identified the following challenges facing people accessing mental healthcare and living in rural, regional and remote areas:

- infrastructure issues that create a barrier to accessing services, including: the need to travel long distances for appointments, no or very limited public transport services in most rural areas, and technology issues that can undermine tele-health solutions
- workforce issues, such as: high staff turnover and unfilled positions, the lack of psychologists and counsellors outside urban areas, a preponderance of inexperienced, newly qualified staff, and the pressing need for more mental health professionals and workers from Aboriginal and Torres Strait Islander backgrounds
- social and cultural factors, including: perceived stigma, a feared loss of privacy and confidentiality in small communities, and impacts from the constant turnover of mental health workers, which can affect the level of understanding service providers have about local cultural issues, as well as making it difficult for clients to build trusting relationships.[310]

Bunyarra Counselling and Mediation told the committee of the barriers to help-seeking in rural and regional areas, such as Kingaroy:

> … we are looking at everyday workers, students, tradesmen and farmers who are taking their own lives and struggling with mental health. These are often the ones who do not have the capacity to reach out and get support because they are normally working 12- to 14-hour days. They cannot get into town. They

[308] Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 142; in-text citations removed.

[309] Submission 151, p 76.

[310] Submission 41, p 7.

cannot drive 100 kilometres to access support. There is also a pride factor in reaching out and going to get these supports too, so a lot of this support is about reducing stigma and creating education.[311]

5.5.4.1 Innovating rural and regional service provision

In response to the challenges facing people living in rural and regional Queensland, Outback Futures, a not-for-profit organisation, has developed a Community Facilitation Model. The model provides significant low and moderate intensity clinical services for remote communities and seeks to facilitate an integrated and collaborative approach to whole of community mental health and wellbeing. [312]

Outback Futures submitted that individuals are supported within the context of family, community, and culture, through multidisciplinary teams using a combination of face-to-face and telehealth service delivery.[313]

The Community Facilitation Model is supported by 4 key pillars:

- Pillar 1: Outback Future innovative WiWo workforce model[314]
- Pillar 2: A commitment to broad community mapping and engagement
- Pillar 3: A unique combination of face-to-face multidisciplinary clinics and telehealth
- Pillar 4: A parallel whole of community primary prevention initiative HEAD YAKKA.[315]

According to Outback Futures, these pillars contribute to reducing the barriers to help-seeking and building genuine self-efficacy as communities begin to better understand, value, manage and advocate for their own mental health needs and pathways. [316]

Outback Futures submitted that to date, the model has been implemented in 9 remote regions in Queensland. Outback Futures advised it is a proven approach to significantly increasing the likelihood of better mental health and wellbeing outcomes in remote communities and is replicable and scalable for other remote regions of Australia.[317]

The committee also notes the work of the Royal Flying Doctor Service (RFDS) in delivering mental health services to rural and remote Queensland. According to the RFDS, it receives funding from governments and donors to bridge the gap in access to mental health services and provides a range of mental health services, including visiting mental health clinics, 24 hour telehealth services, and emergency air transfers of people requiring city based acute care.

RFDS mental health professionals visit remote towns and properties to provide further treatment, support, as well as education about mental health issues for individuals and communities.

The RFDS Queensland reportedly delivers more than 12,100 mental health consultations annually and has the largest mental health service of RFDS service sections in Australia. The RFDS operates

311 Public hearing transcript, Kingaroy, 20 April 2022, p 15.

312 Submission 43, p 5.

313 Submission 43, p 5.

314 The WiWo model involves a dedicated multidisciplinary team recruited to each local government area, regular in-community visits by clinicians to establish rapport with clients and build trusted relationships, and includes follow-up telehealth appointments with the same clinician to ensure consistency, accessibility and client confidentiality. See submission 43, p 5.

315 Submission 43, p 5.

316 Submission 43, p 5.

317 Submission 43, p 5.

in areas as remote as Lockhart River in the Cape York and Camooweal on the Northern Territory border.

RFDS Queensland's Mental Health and Wellbeing Service provides a range of services, including:

- the Outback Mental Health Service which consists of 3 mental health programs operating across parts of Western Queensland — Drought Wellbeing Service, the Remote Wellbeing Service and Wellbeing Out West
- the Far North Mental Health and Wellbeing Service which supports people living in communities across Far North Queensland by providing culturally appropriate, evidence-based, psychological therapies to individuals who present with mild to moderate mental health needs
- the Central West Mental Health and Wellbeing Service operates on a hub-and-spoke model with the Longreach office which is a primary base for clinicians providing services in surrounding communities.[318]

Committee comment

The committee notes that while the prevalence of mental illness is similar in urban and regional Australia, the outcomes are worse for people living in rural areas.

The committee has heard of the considerable challenges of accessing treatment and support in rural and remote Queensland, particularly for people who are considering, or who may have attempted, suicide.

See also section 6.6 for recommendations about regional planning of mental health and AOD service delivery and section 7.4.2 for recommendations about incentivising the rural mental health and AOD workforce.

Recommendation 7 – Improve service provision to rural and regional Queensland

The committee recommends the Queensland Government investigates the viability of expanding service models such as the Outback Futures Community Facilitation Model, the Royal Flying Doctor Service, or similar, to improve low and moderate intensity service provision in rural and regional Queensland.

5.5.5 Housing and homelessness

Queensland has recently experienced a significant reduction in the availability of affordable housing with vacancy rates reduced to less than 1% in most regional towns.[319]

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. 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.[320]

The Queensland Alliance for Mental Health (QAMH) advised that:

> People living with mental illness are more likely to experience housing instability. Figures from the AIHW on the delivery of specialist homelessness services to nearly 14,000 Queensland clients in June 2021 reveal that 3,395 had a mental health issue and 871 reported a problematic alcohol or drug issue. In

[318] Royal Flying Doctor Service, 'Mental Health and Wellbeing', https://www.flyingdoctor.org.au/qld/what-we-do/mental-health/.

[319] Queensland Alliance for Mental Health, submission 119, p 17.

[320] Queensland Mental Health Commission, submission 151, p 107.

> Queensland, 15 per cent of households on the Housing Register waiting for long-term social housing were assessed as having difficulty accessing housing due to a member of the household having a mental illness.[321]

The QMHC submitted that access to secure, affordable and appropriate housing remain under increasing and sustained pressure due to several factors, including:

- 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
- increasing levels of homelessness.[322]

The AIHW explained the connection between housing and physical health and the disproportionately poorer access to adequate housing for Aboriginal and Torres Strait Islander peoples:

> Two critical factors connecting housing conditions to health are the state of domestic health hardware (the physical equipment and infrastructure needed to support good health) and the impact of overcrowding. Housing not only provides shelter and safety, but also supports family, culture and cultural practices—while the lack of available and adequate health hardware can lead to illness or injury. Compared with non-Indigenous Australians, Indigenous Australians have less access to adequate, affordable or secure housing and are more likely to live in overcrowded conditions or to experience homelessness. Dwellings that are inadequate for the number of residents, including long-term visitors, may result in premature failure of health hardware and lead to poor health outcomes.[323]

5.5.5.1 Housing programs assisting people experiencing mental ill-health

Common Ground Queensland submitted that access to supportive housing leads to improvements in quality of life while decreasing the need for clinical treatment and crisis intervention for people who are experiencing mental ill-health.[324]

According to Brisbane South PHN, supportive housing involves:

> … involves the intentional and long-term connection of secure and affordable housing with support. It is an innovative and proven model which follows the Housing First approach. Supportive housing is effective for people who need safe housing that is closely integrated with support services–typically, people who have been chronically homeless and/or people with complex or high support needs, including people with mental illness.[325]

The Common Ground supportive housing model is designed to accommodate and support people experiencing multi-layered challenges. The model is based on 6 key principles:

- permanency and affordability of housing: permanent housing with rent set at no more than 30% of income
- tenancy mix: to ensure a vibrant and diverse building community, tenancies are offered to people who have experienced homelessness and to people with low incomes

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321 Submission 119, p 9. Footnotes in original omitted.

322 Submission 151, p 107.

323 Australian Institute of Health and Welfare, *Australia's health 2020: data insights*, 'Summary', 23 July 2020.

324 Submission 81, p 1.

325 As cited in Micah Projects, submission 131, p 54.

- safety and security: 24/7 concierge ensuring a welcoming but controlled and secure access to the building
- on-site support services: 24/7 access to support worker with additional wrap around holistic health and support services
- social inclusion: maximising independence and personal empowerment within a connected community
- design: thoughtfully designed and well maintained home environment that also serves as an asset to the community.[326]

An evaluation undertaken by the University of Queensland assessed whether Common Ground Queensland was successful in assisting tenants to maintain secure housing and improve their health, wellbeing, social and economic outcomes. Four dimensions of the project were examined including:

- the implementation of the initiative
- effectiveness of building design and performance
- effectiveness of the supportive housing service in achievement of service objectives
- value for money of the model.[327]

In relation to the evaluation, Common Ground Queensland submitted:

> Responses from the first round of tenant interviews conducted as part of the evaluation reveal 67% of participants disclosed having been diagnosed with a mental illness. 70% indicated their mental health condition had improved since being housed at Brisbane Common Ground. 56% reported they were better able to access treatment and manage their mental health.[328]

To address some of the challenges posed by the lack of housing availability in Queensland, the QAMH suggested:

- increasing funding for head-leased housing options for targeted access by people with lived experience of mental illness
- funding support programs that focus on tenancy sustainment
- providing growth funding for subsidised housing options aimed at addressing the needs of people with lived experience of mental illness
- at a national level, putting pressure on the Australian Government to ensure the intersection of mental health and housing services is clearly articulated in the upcoming National Mental Health and Suicide Prevention Agreement.[329]

Q Shelter submitted that tenancy sustainment is a way of working to ensure long term sustainable housing solutions are achieved. Q Shelter supports a tenancy sustainment framework that integrates different types of intervention based on assessed need. Key elements of the framework include diverse housing options, specialist support (such as mental health), regional care coordination groups, informed consent, shared information, and workforce development.[330]

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326 Common Ground Queensland, submission 81, p 2.

327 Submission 81, p 3.

328 Submission 81, p 3.

329 Submission 119, p 17.

330 Submission 148, pp 2-3.

Q Shelter added:

> For people living with mental health challenges, this means that accessing or sustaining housing is not only the responsibility of housing providers or support providers. Tenancy sustainment must involve an effective relationship between housing provision and support provision. It might also involve other inputs depending on the situation. Any dichotomy that proposes tenancy sustainment is either the responsibility of the housing provider or support provider will fall short of achieving the most obvious outcome of ending homelessness and sustaining an end to homelessness.[331]

Committee comment

Access to safe, secure, and affordable housing is inextricably linked to better health outcomes. The committee notes that the relationship between social determinants of health such as housing, homelessness, mental ill-health and problematic alcohol and other drug use is strongly interrelated, highly complex and bidirectional.[332]

The committee has heard of the significant reduction in the availability of affordable housing, particularly in regional communities. The committee also notes that the impact of the housing shortage is greater for Aboriginal and Torres Strait Islander peoples who have less access to adequate housing and are more likely to live in overcrowded conditions, or experience homelessness.[333]

The committee acknowledges the work already being undertaken by the Queensland Government to increase the available stock of secure and affordable housing in Queensland which has been delayed due to the impact of COVID-19 on the construction sector.

The committee notes that the Productivity Commission commenced a review of the *National Housing and Homelessness Agreement* in 2021 with an expected completion date in August 2022.[334] This is intended to inform any future Commonwealth-state housing arrangements.[335]

The committee acknowledges the importance of effective tenancy sustainment strategies in ensuring an end to homelessness, particularly for people experiencing mental ill-health.[336]

The committees notes that following the passing of the Housing Legislation Amendment Bill 2021 on 14 October 2021, the Queensland Government is implementing phased legislative changes. The second phase of reforms is due to commence on 1 October 2022 and will:

- remove the option to end a tenancy without grounds and instead provide tenants and property owners/managers with a wider range of reasons to end a tenancy with appropriate notice
- introduce a framework for parties to negotiate renting with pets, including:
    - prescribed reasonable grounds for refusing a request to keep a pet (eg keeping a pet would breach laws or by-laws)

331 Submission 148, pp 2-3.

332 Queensland Mental Health Commission, submission 151, p 87.

333 Australian Institute of Health and Welfare, *Australia's health 2020: data insights*, 'Summary', 23 July 2020.

334 The National Housing and Homelessness Agreement commenced on 1 July 2018 and provides around $1.6 billion each year to states and territories to improve Australians' access to secure and affordable housing across the housing spectrum.

335 Australian Government, Productivity Commission, 'Housing and Homelessness Agreement Review', https://www.pc.gov.au/inquiries/current/housing-homelessness#report; Australian Government, *National Mental Health and Suicide Prevention Plan,* 11 May 2021, p 10.

336 Q Shelter, submission 148, pp 2-3.

- timeframes for property owners/managers to respond to any requests for a pet. If the property owner/manager does not meet these deadlines the request will be considered approved.

Recommendation 8 – Improve access to secure and affordable housing in Queensland

The committee recommends the Queensland Government:

a) investigates and implements options to increase the available stock of:
   i. public, community and affordable housing
   ii. supportive housing services, such as those provided by Common Ground Queensland.

b) increases case management support services to people living in public, community and affordable housing, including consideration of suitably qualified and/or additional staff to provide relevant psychosocial support.

c) investigates and implements tenancy sustainment strategies and progresses rental reforms.

5.5.6 People living with intellectual or developmental disability

The Mater Intellectual Disability and Autism Service (MIDAS), Mater and the Queensland Centre for Intellectual and Developmental Disability (QCIDD), and the Mater Research Institute-University of Queensland provided a joint submission (Mater joint submission) highlighting the inequities facing Queenslanders with intellectual or developmental disability in accessing mental health services.[337]

The term intellectual and developmental disability (IDD) is used to refer to intellectual disability and developmental disabilities, including autism.[338]

There are approximately 80,000 Queenslanders with intellectual and/or developmental disability, including autism. Intellectual disability is characterised by significant limitations in intellectual functioning, difficulties in adaptive behaviour, with the conditions manifesting before adulthood. Autism is a developmental condition associated with differences in social interactions and communication, repetitive patterns of behaviour and sensory sensitivities.[339]

It is important to note, that intellectual disability, developmental disability, and autism themselves are not mental health conditions. However, people with IDD experience mental health conditions at an earlier age and at higher rates than the general population. Mental health conditions are 2 to 3 times more prevalent for people with intellectual disability compared to the general population. [340]

Autism is associated with higher levels of mental illness and autistic people experience a nine-fold increased risk of suicide. Autistic people, particularly those without a childhood diagnosis, are commonly misdiagnosed, or have comorbid major mental illness such as chronic schizophrenia or bipolar disorder, and therefore are likely to be over-represented among those accessing mental health services.[341]

337 Submission 130, p 4.

338 Mater Intellectual Disability and Autism Service (MIDAS), Mater and the Queensland Centre for Intellectual and Developmental Disability (QCIDD), Mater Research Institute-University of Queensland, submission 130, p 4.

339 Mater joint submission, submission 130, p 4.

340 Mater joint submission, submission 130, p 4. NB: in-text referencing removed. Refer to original source for more information.

341 Mater joint submission, submission 130, pp 4-5.

The Mater joint submission advised that people with IDD experience some of the greatest health disparities in our country. For example:

> People with intellectual disability die up to 27 years earlier and autistic people die up to 17 years earlier than people without disability. Much of this health gap is preventable with a recent Queensland review of the deaths of people with disability finding that 53% of deaths were preventable. The accessibility of health services, or lack thereof, contributes to the significant health gap this population experiences, with key barriers including lack of capacity of mainstream mental health services and staff.[342]

The QCIDD described the historical and ongoing reluctance of psychiatrists to work with people with IDD:

> Queensland research with psychiatrists repeated through the 1990s, 2000s and more recently shows us that psychiatrists lack confidence in their ability to work with people with intellectual developmental disability, and quite a significant proportion would rather avoid working with this population if they could. These findings have not changed since the 1990s. The fact that a significant proportion of our psychiatrists would rather not work with this population points to the stigma and discrimination these people experience when they are trying to access mental health services. When people do manage to access services there are no suitable inpatient treatment facilities, so this group is incredibly vulnerable in our public mental health units.[343]

According to the Mater joint submission, mainstream mental health services have systemically poor knowledge of IDD, and this contributes to the discrimination, inaccessible service, and care environments, and ultimately, the disproportionately poorer mental health status this population experiences.[344] The Mater joint submission adds:

> While specialist intellectual and developmental disability services exist, funding and staffing constraints substantially limit capacity to meet the mental health needs of Queenslanders with intellectual and developmental disability.[345]

According to the Mater joint submission, MIDAS uses a consultation-liaison model, as opposed to case management or ongoing care models, to provide specialised IDD health and mental health services. MIDAS advised:

> The demand for our service is high and increases annually. High demand for MIDAS is compounded by the lack of services in the private sector related to the lack of mental health professionals trained in intellectual disability.[346]

The Mater joint submission made a number of recommendations, including mandatory education and training for mainstream mental health staff about IDD and expanding service capacity of specialist IDD mental health services.[347]

A/Professor James Morton, who is the parent of a child living with intellectual impairment and mental illness, advised that there is substantial unmet need in the community and very limited expertise to provide care for people with an intellectual impairment and mental illness. A/Professor Morton noted the challenges his family faced, even as a well-resourced and knowledgeable, medical family, were 'profound'.[348]

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342 Mater joint submission, submission 130, pp 4-5.

343 Public hearing transcript, Brisbane, 12 April 2022, p 51.

344 Submission 130, p 2.

345 Submission 130, p 2.

346 Submission 130, p 3.

347 Submission 130, p 13.

348 Submission 4, p 2.

In view of these issues, A/Professor Morton recommended investment in a centralised facility of excellence providing for:

- a specialised intellectual impairment unit located at a Brisbane teaching hospital providing adolescent and adult services.
- the unit foster hospital-wide ability, expertise, and a supportive culture around the psychiatric and broader medical management of people with intellectual impairment.
- the unit provide an outreach community-based service to monitor and support people with intellectual impairment in the community.
- the unit lead a state-wide network facilitating medical and psychiatric care for people with intellectual impairment
- the unit have an academic component to collect data and foster research around the psychiatric and medical needs of people with intellectual impairment in the community.
- the unit train next generation health professional and community support workers to work with and care for people with intellectual impairment in the community.[349]

Committee comment

The committee acknowledges the significantly poorer mental health outcomes experienced by people living with IDD, which are reportedly compounded by systemically poor knowledge of IDD and funding constraints.

The committee notes the demand on public specialist IDD services is exacerbated by a lack of private sector services. This lack of services is related to the limited numbers of mental health professionals trained in IDD.

Given that deaths related to mental-ill health are preventable, there is a need to better support this vulnerable cohort of people in Queensland. It is the committee's view that investing in a research centre of excellence will provide avenues to develop Queensland's IDD specialist care network and grow the evidence base to support clinicians and people living with IDD.

Recommendation 9 – Enhance mental health services for people living with intellectual or developmental disability

The committee recommends the Queensland Government:

a) invests in a centre of excellence for intellectual or developmental disability and neurodivergent conditions, such as the Mater Intellectual Disability and Autism Service.

b) establishes more nurse navigator roles to help people living with intellectual or developmental disability and their families navigate the mental health services available to them.

5.5.7 Culturally and linguistically diverse communities

It is acknowledged that people from CALD backgrounds in Queensland, including refugees and people seeking asylum, are particularly vulnerable to poor mental health outcomes.[350] Their

[349] Submission 4, p 2.

[350] See, for example, headspace, submission 66 p 13; Australian Psychological Society, submission 63, p 3; DVConnect, submission 85, p 4; QPASTT, submission 86; Department of Children, Youth Justice, and Multicultural Affairs, public hearing transcript, Brisbane, 11 February 2022, p 2.

experiences can be exacerbated by other disadvantages that are associated with language and cultural barriers, including housing stress, unemployment or insecure employment.[351]

QPASTT advised that a 2017 survey found that between 36% and 41% of former refugees who had resettled in Australia and responded to the survey were classified as having moderate to high risk of psychological distress, which is more than 3 times higher compared to the rates for the broader population.[352] QPASTT continued:

> Exposure to multiple adverse events on the migration journey coupled with post-settlement stressors, which are encountered as people adjust to their new lives in Australia, were identified as risk factors contributing to these higher rates of psychological distress. These are in effect the social determinants of refugee trauma. Of our current client group being serviced, 23% have experienced some form of torture including physical, psychological or sexual torture or chemical, sensory or environmental manipulation. Additionally, 76% of clients report experiencing traumatic events including arbitrary imprisonment, kidnapping, witnessing death or harm to a significant other, destruction of home, communal violence, forced involvement in combat (including as a child solder) and general deprivation and hardship.[353]

Suicide Prevention Australia stated that mental health outcomes for Australians from CALD backgrounds can also be affected by 'reduced and variable rates of access to mental health services, despite potentially having higher needs due to migration stressors'.[354]

QPASTT advised that the following were barriers that people from refugee backgrounds experience when interacting with the mental health system:

- a significant underutilisation of services across the care continuum with children from non-English speaking backgrounds shown to be the least likely to access mental health services
- stigma continues to be a significant barrier to access
- people's past experience of torture and trauma at the hands of authority figures overseas increases the reluctance to engage with government services
- practical barriers including:
    - negative past experiences with healthcare professionals
    - lack of knowledge about the refugee experience
    - lack of use of interpreters
    - lack of feeling of cultural safety
    - fear that information won't be kept confidential and authorities such as the Department of Immigration may be informed
    - the costs and complexity of engaging with mental health services.[355]

QPASTT also highlighted that people seeking asylum have a unique set of circumstances that can contribute to mental health outcomes and create barriers to access, including:

- the major stressor relates to the resolution of immigration status, particularly if they have been waiting for an extended period of time

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351 Department of Children, Youth Justice, and Multicultural Affairs, public hearing transcript, Brisbane, 11 February 2022, p 2.

352 Submission 86, p 5.

353 Submission 86, p 5.

354 Submission 25, p 20.

355 Submission 86, pp 5, 6.

- a sense of powerlessness, loss of hope and perception about the welcome they would receive in Australia
- secondary trauma from extended detention and a decline in pre-existing internal emotional coping strategies and regulation
- heightened and long-lasting states of distress due to difficulties with living conditions (severe financial stress often without the means to change this situation due to visa restrictions, such as lack of work rights, deteriorating mental health, transient housing)
- generalised lack of trust in systems that may help
- lack of access to Medicare for some people
- lack of work rights or income support for some asylum seekers
- fear of the Department of Immigration finding out about their mental health status if they access services.[356]

QPASTT recommended increased investment to develop a trauma-informed culturally responsive service system which is accessible to all people from culturally diverse backgrounds and reduces current barriers to equitable participation. QPASTT submitted that 2 key strategies are required:

- co-design with communities from refugee backgrounds on ways the mainstream mental health service system can be improved. This includes the development of a suite of intake, assessment and referral processes to be used in mainstream mental health services, both clinical and community, that are informed by an understanding of complex refugee trauma
- delivery of a professional development program for the mental health workforce that builds not only cultural capability but a deeper understanding of the impact of complex refugee trauma.[357]

According to QPASST, the Multicultural Mental Health Coordinator Program of the Queensland Transcultural Mental Health Centre is critical for facilitating culturally responsive mental health care. QPASST advised that this program could benefit from expansion as well as the employment of liaison workers from refugee backgrounds who are able to support access and improve navigation of supports.[358]

The Queensland Transcultural Mental Health Centre (QTMHC) is a specialist state-wide service that works to ensure people from culturally and linguistically diverse (CALD) backgrounds receive culturally responsive mental health care and support. QTMHC is a state-wide MHAOD service hosted at Metro South Hospital Health Service. It provides state-wide specialist mental health consultation services for people from CALD backgrounds across all ages and across the continuum of care.[359]

The World Wellness Group, an independent multicultural health social enterprise, stated that 'multicultural lived experience is a missing voice in the mental health system due to limited investment in the multicultural lived experience workforce'.[360]

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356 Submission 86, pp 6, 7.

357 Submission 86, p 3.

358 Submission 86, p 6.

359 Metro South Addiction and Mental Health Service, *Action Plan 2021-2026*, Queensland Transcultural Mental Health Centre, p 3.

360 Submission 59, p 3.

According to World Wellness Group its pro-active social health model addresses the social determinants of housing, employment, legal, family violence, discrimination, language and cultural barriers impacting adversely on our clients in an embedded wraparound model of care.[361]

World Wellness Group submitted that lack of access to justice is well documented for vulnerable people such as CALD people with mental health issues and that its Health Justice Partnership Model is an evidence-based model providing legal assistance to client facing complex legal matters compounding their existing social disadvantage.[362] World Wellness Group added:

> There are many excellent initiatives in the mental health sector that do not fit existing funding streams as they fill the gaps. One such example in WWG is a health justice program we have self- funded via fundraising and donations for several years given the large number of our clients with legal issues falling through the gaps in the justice system which exacerbated their mental health issues.
>
> …
>
> Advice from both the Departments of Health and Justice and Attorney General was, whilst we were achieving excellent outcomes, that our work fell between the two departments and that there is no funding pathway as we are filling a gap. We would have thought that such critical gaps require more flexible approaches to funding pathways.[363]

5.5.7.1 Invisibility of CALD groups in mental health data and policy

The World Wellness Group advised that CALD populations are not explicitly identified as a priority population for funding:

> … there is no visible funding stream in Primary Health Networks and the last tender for community based mental health services with Queensland Health proceeded on the basis that mainstream mental health services could adequately provide for the needs of the CALD population. Without significant high-level advocacy on our part there would be no dedicated multicultural mental health psycho-social service such as Culture in Mind which at present only covers the Greater Brisbane region. Dedicated multicultural primary mental health care services are now funded by the Brisbane PHNs following significant advocacy but are yet to be funded outside Brisbane as there is no specific funding stream for CALD.[364]

The World Wellness Group submitted that in 2019 it raised with the Minister for Health and Ambulance Services the invisibility of CALD health issues in policy, reportedly due to the lack of CALD specific data collection and analysis by Queensland Health. This advocacy led to the commitment of 3 CALD data roundtables, the third of which was deferred due to the COVID-19 pandemic.[365]

The World Wellness Group advised that the pandemic highlighted the difficulty in reaching multicultural communities with targeted public health strategies who were disproportionately affected by COVID-19. The lack of data means there is limited ability to develop evidence-based and data informed service improvements for the CALD population. To address these issues, the World Wellness Group recommended that the third data roundtable be held to inform mental health service provision to Queensland's CALD communities.[366]

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361 World Wellness Clinic, 'Health Promotion and Advocacy', https://worldwellnessgroup.org.au/health-promotion/.

362 World Wellness Clinic, 'Health Promotion and Advocacy', https://worldwellnessgroup.org.au/health-promotion/.

363 Submission 59, p 7.

364 Submission 59, p 4.

365 Submission 59, p 5.

366 Submission 59, p 6.

Committee comment

The committee acknowledges that people from CALD backgrounds are at risk of poorer mental health which can be exacerbated by disadvantages that are associated with language and cultural barriers, including housing stress, unemployment or insecure employment.[367]

The committee notes the high prevalence of significant trauma experienced by people from CALD backgrounds related to their migration journeys which can be compounded by post-settlement stressors.[368] This trauma can be associated with a reluctance to engage with government services.[369]

The committee notes the work of the Queensland Transcultural Mental Health Centre and has heard evidence that this service could benefit from expansion. It is the committee's view that there is a need to better support people from CALD backgrounds to ensure they are connected with culturally appropriate services that meet their mental health and wellbeing needs.

Recommendation 10 – Improve health data for people from culturally and linguistically diverse communities

The committee recommends the Queensland Government re-convenes data roundtables with the World Wellness Group and other key stakeholders to capture health data for culturally and linguistically diverse communities to inform public health service delivery.

Recommendation 11 – State-wide service to support the health and wellbeing of people from culturally and linguistically diverse backgrounds

The committee recommends the Queensland Government reviews existing culturally and linguistically diverse health and wellbeing services, identifies opportunities for improvement and expands or establishes these services across the state to provide more support to culturally and linguistically diverse communities.

5.5.8 Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning or Asexual (LGBTIQA+) community

People from Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning or Asexual (LGBTIQA+) communities have higher rates of mental ill-health and suicide than the general population.[370]

While not all LGBTIQA+ people experience challenges in their lives, many do. The Queensland Council for LGBTI Health reported that mental health challenges, suicidal thoughts and attempts, harassment and abuse, homelessness, challenges with alcohol and drug use and intimate partner and family violence are some of the areas that are disproportionately experienced by LGBTIQA+ people, with specific subgroups experiencing additional burdens.[371]

Rainbow Families Queensland, a not-for-profit organisation delivering services to the LGBTIQA+ community, submitted that based on the latest health data, the mental health of the community is in crisis. Rainbow Families Queensland added:

> Lesbian, gay and bisexual people are twice as likely to be diagnosed and treated for mental health disorders in Australia and are 5 times more likely than those in the general population to attempt suicide. Transgender people are at substantially higher risk of suicide attempts (at 11 times the general

[367] Department of Children, Youth Justice, and Multicultural Affairs, public hearing transcript, Brisbane, 11 February 2022, p 2.

[368] Submission 86, p 5.

[369] QPASTT, submission 86, pp 5-6.

[370] Suicide Prevention Australia, submission 25, p 19.

[371] Submission 145, p 6.

population). 60% of Australians with an intersex variation had thought about suicide based on issues related to having a congenital sex variation.[372]

The Queensland Council for LGBTI Health advised that it recently consulted with its communities about mental health and heard that:

- current access to supports needs to be improved and strengthened to ensure individuals and communities have adequate access to support for them, their families, friends and chosen families
- more sector funding is needed to expand existing LGBTIQA+ Sistergirl and Brotherboy services, expanding services to help individuals and communities access services
- referral pathways need strengthening and improving sector capability to allow more culturally safe ways to access mental health supports, doctors, clinicians, and crisis support.[373]

Rainbow Families Queensland identified the following priority areas to respond to the challenges experienced by the LGBTIQA+ community in Queensland:

- targeted funding for at risk marginalised communities, prioritising community-led solutions
- specific training for mainstream mental health service providers to increase awareness and understanding of rainbow families and LGBTIQA+ communities to ensure services are inclusive, accessible, affordable and appropriately targeted
- strengthening and enhancing the overall capacity of the system supporting social inclusion.[374]

Committee comment

The committee notes that Queensland's LGBTIQA+ community experiences disproportionately higher rates of mental ill-health and suicidality. The LGBTIQA+ community requires more support to ensure they are connected with inclusive services that meet their mental health and wellbeing needs.

Recommendation 12 – State-wide service to support health and wellbeing of the lesbian, gay, bisexual, transgender, intersex, queer/questioning or asexual (LGBTIQA+) community

The committee recommends the Queensland Government reviews existing lesbian, gay, bisexual, transgender, intersex, queer/questioning or asexual (LGBTIQA+) health and wellbeing services, identifies opportunities for improvement and expands or establishes these services across the state to provide more support to LGBTIQA+ communities.

5.5.9 Alcohol and other drug use

There is a strong association between the use of alcohol, tobacco and illicit drugs and mental illness. Research has found that use of these substances, either episodically or over an extended period, can not only trigger or exacerbate mental ill-health, but is strongly associated with physical health, including cancer, cirrhosis, and cardiovascular disease. People experiencing mental ill-health are more

372 Submission 146, p 2.

373 Submission 145, p 3.

374 Submission 146, p 4.

likely to use tobacco, alcohol and illicit drugs, and may do so as a coping strategy in response to their symptoms.[375]

The Alcohol and Drug Foundation (ADF) advised that AOD use can also contributed to other life stressors such as challenges with employment, finances, housing and maintaining relationships. According to the ADF, strong links exist between alcohol and drug use and suicide.[376]

The QMHC found that in Queensland and nationally, most harm and cost is associated with the problematic use of alcohol. The most prevalent illicit drug use is associated with cannabis, ecstasy and methamphetamines, as well as the misuse of analgesics.[377]

Queensland Health advised that 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.[378]

The ADF said that 4.7 million Australians are using alcohol in a harmful way, but they are not seeking treatment because 'their problems are not considered to be significant enough, or they might be having problematic use of alcohol but the social norms around alcohol use mean that that has not crystallised for that individual, or their family or their friends yet'.[379]

The ADF added that there is a 'huge opportunity to intervene early in that group in a much more cost-effective way to avoid the need for treatment and all of the social issues that arise for people when they may have a substance use disorder going forward'.[380]

In relation to the harms of AOD, the QMHC stated:

> The risk and extent of harm is influenced by a range of factors specific to the individual, the type and purity of drugs used, and the environment. Associated harm may be experienced in the short term (i.e. accident or injury) or longer term (i.e. disease).[381]

The ADF submitted that for people aged 25 to 44, mental health and substance use disorders are the leading cause of burden of disease. The ADF added:

> For adolescent males, suicide and self-inflicted injury is the leading cause of burden of disease, with alcohol use ranked second, and we also know that alcohol and other drug use contributes to those suicides and self-inflicted injuries. Alcohol and other drug use are the second and third leading risk factors for male suicide and self-harm, and the third and fourth risk factors for women.[382]

5.5.9.1 Harm reduction strategies

QuIVAA defined harm reduction as:

> … a way of working, essentially; it is a framework for a way a service works. It is often put in opposition to abstinence or a different approach to abstinence based services or other models. It is essentially meeting people where they are at and working with practical, realistic goals for people around their substance use and essentially being less focused on the drug use itself and more focused on improving

375 Australian Institute of Health and Welfare, *Australia's health 2020: Physical health of people with mental illness snapshot*, 23 July 2020; Australian Institute of Health and Welfare, *Alcohol, tobacco & other drugs in Australia*, web report, 20 April 2022; Public hearing transcript, Brisbane, 16 February 2022, p 14.

376 Public hearing transcript, Brisbane, 16 February 2022, p 14.

377 Queensland Mental Health Commission, *Shifting Minds – Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023*, p 12.

378 Submission 150, p 106.

379 Public hearing transcript, Brisbane, 16 February 2022, p 24.

380 Public hearing transcript, Brisbane, 16 February 2022, p 24.

381 Queensland Mental Health Commission, *Shifting Minds – Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023*, p 12.

382 Submission 69, p 4.

> people's overall health and reducing harms. A lot of the harms are those social harms for people which do not come from the drug use itself but come from stigma and not great drug policy, essentially. Harm reduction is about identifying those kinds of systemic changes as well and where you can make improvements in people's lives.[383]

The ADF submitted that drug use is a health issue, and when people want to reduce or cease their use of drugs, support will be most effective when delivered through the various AOD treatment services and other healthcare options. The ADF added:

> The justice system does not specialise in providing healthcare and as such, is not an effective tool for helping people manage a health issue.
>
> Interactions with the justice system often exceed the harms that may be associated with drug use itself. In addition to the stigma experienced by people who use drugs, which delays or prevents help-seeking, people who become involved in the justice system because of drug use can also experience long term negative impacts on their social, employment, housing, and travel opportunities which can further contribute to mental ill health.[384]

The ADF explained that these harms are disproportionately experienced by some of the most vulnerable communities, including Aboriginal and Torres Strait Islander peoples, CALD communities and young people. The ADF recommended adopting an approach that 'frames drug use as a health issue can reduce the stigma and discrimination experienced by people who use drugs, making it more likely that people will reach out for help with their AOD use when they want it'.[385]

QNADA advised that there is substantial return on investment for alcohol and drug treatment, including harm reduction strategies; however, funding is only 'half of what is required to meet demand'. QNADA explained:

> The right amount of funding in the right place is critical for good treatment outcomes. New investment should also prioritise protective responses rather than punitive responses to alcohol and other drug use and include a diversity of treatment options including harm reduction strategies. These options should include responses that are amenable to families, as well as residential and non-residential treatments available to those on remand and in prison.[386]

Committee comment

The committee notes that harm minimisation is an approach to alcohol and other drugs policy that includes demand reduction, supply reduction and harm reduction. Harm reduction refers to evidence-based interventions that aim to reduce the adverse health, social and economic consequences of the use of alcohol, tobacco and other drugs.[387]

Harm minimisation underpins both the Australian Government's *National Drug Strategy 2017-2026* and the Queensland Government's *Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023*.

383 Public hearing transcript, Brisbane, 13 April p 5.

384 Submission 69, p 9.

385 Submission 69, p 9.

386 Submission 48, p 37.

387 Queensland Mental Health Commission, *Shifting Minds – Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023*, p 14.

The committee understands that strategies that provide people who use alcohol and other drugs with early support and divert them away from the criminal justice system are beneficial for individuals and are more cost effective than punitive responses.[388]

The committee is aware of existing Queensland Government initiatives which seek to minimise an individual's contact with the criminal justice system and to refer them to alcohol and drug treatment. The Queensland Government currently administers the Police Drug Diversion and Illicit Drugs Court Diversion Programs.

Recommendation 13 – Strengthen illicit drug diversion initiatives

The committee recommends the Queensland Government reviews illicit drug diversion initiatives, including the Police Drug Diversion Program and the Illicit Drugs Court Diversion Program, and identifies opportunities to strengthen the initiatives.

5.5.10 Interactions with the criminal justice system

The Productivity Commission found that people with mental illness are over-represented throughout the justice system, including in correctional facilities (where the majority are imprisoned for short sentences and often cycle in and out), and as victims of crime. The Productivity Commission reported that there is considerable scope for improved mental healthcare for people in all parts of the justice system.[389]

Stakeholders raised a number of issues about interactions people experiencing mental ill-health have with the criminal justice system.[390]

5.5.10.1 Access to bail

For example, the Office of the Public Guardian (OPG) reported impeded access to bail for clients with a mental health condition:

> OPG has specific concerns about our clients who are on remand in custody with legal proceedings on foot (as opposed to having been sentenced to a term of actual imprisonment). These clients, who have not been sentenced for a crime, experience significant difficulties bringing successful applications for bail within a reasonable timeframe.
>
> Delays and barriers to obtaining NDIS funding and/or examinations for functional needs assessments means these clients are frequently unable to source appropriate accommodation and the relevant supports in a timely manner. As a consequence, these clients have no choice but to serve time in custody, some for lengthy periods, when they are otherwise eligible to apply to be released on bail.[391]

5.5.10.2 Incarcerated populations

The Queensland Forensic Mental Health Service (QFMHS) advised that prisoner populations have nearly doubled over the past 10 years and that the rates of mental disorder and trauma among this group are magnitudes higher than they are for the community. The QFMHS advised 'this is particularly the case for our Indigenous cohort in prisons'.[392]

388 Queensland Mental Health Commission, *Shifting Minds – Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023*, p 14.

389 Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 3, pp 1011 – 1012.

390 See, for example, Office of the Public Guardian, submission 46; Sisters Inside Inc, submission 158.

391 Submission 46, p 6.

392 Public hearing transcript, Brisbane, 28 April 2022, p 48.

Sisters Inside Inc stated that approximately 50% of Queensland people in prison had a prior hospitalisation for a mental health issue.[393]

In relation to women and girls in prison, Sisters Inside Inc reported that most criminalised women live with racism and discrimination and come from backgrounds of poverty, homelessness, sexual or physical abuse, and family and domestic violence. As a result, most criminalised women face mental health (including substance abuse) and/or physical health issues and have experienced significant trauma.[394]

Director of the QFMHS, Dr Ed Heffernan, advised the committee of the 'fractured' structure of forensic mental health services in Queensland, and drew the committee's attention to the first 10 recommendations of a 2016 Queensland Health report titled, *When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services*.[395]

Recommendations 1 to 10 of the report are as follows:

1. Develop an integrated state-wide forensic mental health service with a governance structure independent of Hospital and Health Services that enables the effective operation and maintenance of an integrated service across Queensland.
2. The position of Director of a state-wide forensic mental health service is to have state-wide oversight of the integrated service, which provides and supports independence, governance, integrated standards and consistent practices.
3. Establish quarterly meetings between the Director of the state-wide forensic mental health services and Hospital and Health Services mental health service senior executives to improve quality, efficacy and integration of services.
4. State-wide forensic mental health services are provided to consumers assessed as being at a high risk of violence in addition to consumers on forensic orders under the *Mental Health Act 2000.*[396]
5. The role and function of the Forensic Liaison Officer positions located within mental health services be quarantined for undertaking assessments and management of forensic mental health consumers and other consumers who pose a high risk of violence.
6. Develop collaborative and effective relationships between forensic mental health services and Hospital and Health Services mental health services staff and obtain knowledge of the models of mental health service delivery and available services/resources within the HHS region, by ensuring that identified Community Forensic Outreach Services teams are attached to specific HHSs, thus ensuring teams and clinicians assigned gain an increased understanding of the HHS necessary to provide tailored support to that specific HHS mental health service.
7. Upon completion of an assessment and prior to the finalisation of the recommendations state-wide forensic mental health services staff are to discuss their findings with the Hospital and Health Services (HHS) mental health service clinicians responsible for the consumer's care to enhance validity of the recommendations and to help ensure that they reflect the availability of resources and services in the HHS.
8. Develop a categorisation system to differentiate lower risk from higher risk consumers on forensic orders and adjust the treatment and monitoring requirements accordingly.

393 Submission 158, p 2.

394 Submission 158, p 2.

395 Public hearing transcript, Brisbane, 28 April 2022, p 51.

396 Now *Mental Health Act 2016*.

9. Consider the engagement model of Mental Health Intervention Coordinators with the Queensland Police Service in responding to potential mental health crisis situations as a component of the service delivery model for state-wide forensic mental health services.
10. The comprehensive assessments conducted by clinicians must be informed by collateral information obtained from families/carers. Prompts on obtaining this information are to be added to the State-wide Standardised Suite of Clinical Documentation and, where no collateral is provided, the efforts made to contact and obtain the information are to be documented and audited.[397]

Dr Heffernan advised that there are 'extremely positive service elements within the forensic mental health system to build on'; however, he noted that there is a gap in 'the statewide coordination of services: ensuring quality, safety, consistency, equity'. In response to this, Dr Heffernan recommended consideration of the above recommendations.[398]

5.5.10.3 Lack of mental health services available in correctional facilities

With respect to the treatment available in prison, Sisters Inside Inc advised:

> We consider it is a tragedy that, for many women, it is only through criminalisation that they are given the opportunity to have their mental health assessed and, if they are lucky, treated by a medical professional. We believe that this treatment should be available as of right, and not only once a woman has been deprived of her liberty.[399]

The Australian Psychological Society (APS) advised that the lack of access to appropriate psychological intervention and services in correctional facilities means that psychologists are often focused on the most pressing cases, concentrated on risk assessment and those with acute suicidality.[400]

The APS added that while some of their members reported delivering group skill-building programs, there is almost no individualised, tailored psychological treatment in correctional facilities. The APS considers this is not only a 'duty of care' issue, but representative of the lost opportunity to address some underlying issues which are likely to have contributed to offending behaviour. [401]

The APS identified the challenges facing forensic populations who remain at risk for relapse and re-entry into the correctional and mental health systems due to:

> …poor access to treatment, limited access to psychosocial supports and services, poor job-related skills, limited accommodation and financial resources, developmental trauma, and so on forth. Ideally, mental health services in prisons should be closely linked with treatment services in the community. Current services in prisons and correctional facilities appear to be unduly limited in scope and time.[402]

QuIVAA explained the challenges for people with drug use concerns when transitioning out of prison:

> We see that for people coming out of prison who have drug use concerns there are often huge barriers for them in the way to reconnect with community. They often come out without a place to live or have inappropriate accommodation. There are often huge barriers in the way for people re-entering the workforce or studying—for example, blue cards, criminal history checks and things like that. Doing those basic things and trying to re-establish themselves in the community can be really challenging.[403]

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397 Queensland Health, *When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services*, 2016, pp 4-6.

398 Public hearing transcript, Brisbane, 28 April 2022, p 49.

399 Submission 158, p 2.

400 Submission 63, p 4.

401 Submission 63, p 4.

402 Submission 63, p 4.

403 Public hearing transcript, Brisbane, 13 April 2022, p 8.

The QFMHS advised that when people leave custody without continuity of care, they die from suicide and overdose rates that are dramatically higher than any other health cohort. The QFMHS added that this cohort also:

> …suffer high rates of relapse and then present to hospitals with complex health problems in the middle of the night or three o'clock in the morning in really highly expensive, service-demanding ways. We also know that they have rates of reoffending that are much higher, and of course you have heard of the revolving door.[404]

As a priority, the Productivity Commission recommended that state and territory governments should, with support from the Australian Government, commit to a consistent policy of no exits into homelessness for people with mental illness who are discharged from institutional care, including hospitals and correctional facilities.[405]

The QFMHS advised that 'if we judge ourselves by how we are treating the most unwell and the marginalised in our community, we are currently failing within our mental health system'. The QFMHS added:

> While investing in the mental health problems of people in the criminal justice system may not be a vote winner, it makes complete sense from a public health perspective. It reduces bad outcomes for individuals, it reduces money that is spent on these individuals and it reduces crime. It is really a public health no-brainer.[406]

5.5.10.4 Sisters for Change

The committee conducted a site visit in Cairns to meet with the Australian Red Cross about its *Sisters for Change* program. *Sisters for Change* is a Community-Based Health and First Aid program run in Townsville Women's Correctional Centre. The Community-Based Health and First Aid program operates in 3 other Australian prisons in New South Wales, Western Australia and South Australia.[407]

The people in prison who are involved in these programs train to become special 'status' Red Cross volunteers within their correctional facility. The program brings people involved with the criminal justice system, prison staff and management and the Red Cross together as partners. The volunteers receive formal qualifications in Basic First Aid and Mental Health First Aid, Cultural Competency and Aboriginal and Torres Strait Islander Health. [408]

After 12 months of the program in Townsville Women's Correctional Centre, the general prison population perceived the prison as safer and relationships with correctional officers to have improved. According to an early evaluation of the program, 75% of the special status volunteers reported they had changed from who they were when they first came to prison, and 50% felt hopeful and positive about the future. [409]

In the first 12 months, *Sisters for Change* reported:

- 53 information sessions were delivered
- 24 women graduated the program

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404 Public hearing transcript, Brisbane, 28 April 2022, p 48.

405 Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 3, p 966.

406 Public hearing transcript, Brisbane, 28 April 2022, p 48.

407 Australian Red Cross, *Community Based Health and First Aid in Action (CBFHA) – Sisters for Change at Townsville Women's Correctional Centre*, p 2.

408 Australian Red Cross, *Community Based Health and First Aid in Action (CBFHA) – Sisters for Change at Townsville Women's Correctional Centre*, p 2.

409 Australian Red Cross, *Community Based Health and First Aid in Action (CBFHA) – Sisters for Change at Townsville Women's Correctional Centre*, p 3.

- 12 volunteer-led community projects were completed
- 362 volunteer hours were recorded.[410]

Committee comment

The committee notes that people who have interactions with the criminal justice system are more likely to have experienced trauma, poverty, homelessness, and physical and sexual abuse. The committee has heard that people who have had contact with the criminal justice system are also more vulnerable to physical health comorbidities and AOD problems.

There is reportedly almost no individualised, tailored psychological treatment currently provided in Queensland's correctional facilities.[411] The committee also heard that without continuity of care, people who are released from custody die from suicide and overdose rates that are 'dramatically higher than any other health cohort'.[412]

The committee acknowledges these populations require greater access to mental health and AOD services while in custody to support positive transitions back into the community when they are released.

The committee has heard evidence that Forensic Mental Health Services in Queensland are fractured, and that this impacts on the delivery of care and treatment to some of the most unwell and marginalised people in the community.[413]

Recommendation 14 – Implement outstanding recommendations from the 2016 review of the forensic mental health service model

The committee recommends the Queensland Government reviews recommendations 1 to 10 of Queensland Health's *When mental health care meets risk: A Queensland sentinel events review into homicide and public sector mental health services* report, and implements any outstanding recommendations.

Recommendation 15 – Increase mental health and alcohol and other drugs service delivery in correctional facilities

The committee recommends the Queensland Government funds:

a) more mental health services in Queensland's correctional facilities and for people on remand, including delivery of one-to-one psychological treatment and group interventions.

b) withdrawal and alcohol and other drugs recovery services in correctional facilities, including for people on remand.

c) programs like 'Sisters for Change' facilitated by the Australian Red Cross across more correctional facilities.

410 Australian Red Cross, *Community Based Health and First Aid in Action (CBFHA) – Sisters for Change at Townsville Women's Correctional Centre*, p 3.

411 Australian Psychological Society, submission 63, p 4.

412 Public hearing transcript, Brisbane, 28 April 2022, p 48.

413 Queensland Forensic Mental Health Service, public hearing transcript, Brisbane, 28 April 2022, p 51.

5.5.11 Employment and workplace mental health

Research evidences that every step up the socioeconomic ladder is accompanied by a benefit for health. The relationship is two-way — poor health can be both a product of, and contribute to, a lower socioeconomic position.[414]

The psychosocial stress caused by unemployment has a strong impact on physical and mental health and wellbeing. Once employed, participating in quality work helps to protect health, instilling self-esteem and a positive sense of identity, while providing the opportunity for social interaction and personal development.[415]

A number of submitters raised the issue of unemployment as a risk factor for poorer mental health.[416] Stepping Stone Clubhouse advised that people with a mental illness, require a range of employment programs, flexible timeframes and flexible support in order to succeed in employment.[417]

As noted above, the committee's first public hearing and site visit was conducted at Stepping Stone Clubhouse in Coorparoo. Stepping Stone Clubhouse described the model as:

> … a membership-based community of people with a mental illness dedicated to rebuilding their lives. Members share ownership and responsibility for the success of the organisation. Through participation in Stepping Stone members are given the opportunities to re-join the worlds of friendships, family, important work, employment and education. Stepping Stone is an environment for people who have had their lives drastically disrupted and need the support of others who believe that recovery from mental illness is possible for all.[418]

Ms Melanie Sennett, Executive Director of Stepping Stone Clubhouse, explained the difficulty that people who are experiencing mental ill-health may have in finding gainful employment, and the benefits of the Clubhouse model in assisting people to find work:

> Historically, people have been given very few choices to assist them with employment. One of those has been a disability employment service provider. They are usually large and they are usually about getting numbers and KPI star ratings and outcomes. What usually happens with that is that people get very little support. They are put into a job and then they are left to fail. At clubhouse we have set up a transitional employment program where we are in the middle. You are at the clubhouse and you are in your own job. We know that interviewing is terrifying and a lot of people do not have a resume filled with things, so we have actually gone and partnered with different employers in the community and set up transitional employment positions. The jobs belong to Stepping Stone, and staff of Stepping Stone actually train in the job first. Then we select the members who go into that. We have been working with the members in the unit so we know our members really well, and members are going to give it a go because they know us as well.[419]

Ms Sennett added that clubhouse members are supported for as long as they need with the goal that after one or more transitional employment positions, until a member may 'be ready to go into their own job':

> We stay with the member for as long as they need and we fill in if that person is sick for the day. Members do not have to worry that 'I might be sick and I might lose my job'; we will just jump in and do that. That gives that member real work, real pay. They become employed by the employer. We do not want it to be

414 Australian Institute of Health and Welfare, *Australia's health 2020: data insights,* 'Socioeconomic position', 23 July 2020.

415 Australian Institute of Health and Welfare, *Australia's health 2020: data insights,* 'Employment and work', 23 July 2020.

416 See, for example, submissions 91, 99, and 103.

417 Stepping Stone Clubhouse, response to additional question published 28 February 2022, p 4.

418 Stepping Stone Clubhouse, correspondence, 25 January 2022, p 1.

419 Public hearing transcript, Brisbane, 27 January 2022, p 3.

> sheltered; we want them to have all of those experiences as well. The idea of that is that after one transitional employment position, or maybe a couple, then somebody might be ready to go into their own job. What we find is that people often then actually go into the educational world. They realise that they need some vocational training, and we help them to do that.[420]

Stepping Stone Clubhouse acknowledged existing the Queensland Government's employment initiative *Skilling Queenslander for Work* however, it advised that there is a need for specific mental health funding to support people into open employment.[421]

5.5.11.1 Workplace mental health

In relation to workplace mental health, the QMHC advised that 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.[422] According to the QMHC, 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
- exposure to trauma.[423]

The QMHC advised of the significant economic benefits in preventing and reducing the impact of work-related disorders:

> The return on investment for initiatives to create a more mentally healthy workforce have been calculated at $2.30 for every dollar invested. International evidence suggests an average return on investment of $4.20 for every dollar. 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.[424]

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420 Public hearing transcript, Brisbane, 27 January 2022, p 3.

421 Stepping Stone Clubhouse, response to additional question published 28 February 2022, p 4.

422 Queensland Mental Health Commission, submission 151, p 80.

423 Submission 151, p 80.

424 Submission 151, p 81; Mater Intellectual Disability and Autism Service (MIDAS), Mater and the Queensland Centre for Intellectual and Developmental Disability (QCIDD), Mater Research Institute-University of Queensland, submission 130, p 4.

The Workers' Psychological Support Service, a free, state-funded support service, identified bullying, violent clients and sexual harassment in the workplace as the 3 most common concerns raised by workers in contact with the service.[425]

The committee also heard from MATES in Construction (MATES) which was established in 2008, following an industry specific review evidencing high rates of suicide in the construction industry. The MATES model is predicated on 'help-offering' in order to eliminate known barriers to help-seeking such as poor psychosocial education, stigma and shame.[426] MATES described its model of support as follows:

> MATES' model of support primarily rests with the development of skills onsite and throughout the industry to observe behaviors, respond to challenge risks and develop supports to safety for colleagues. The model of support also includes case management support when clients need ongoing connection to remain safe and engage clinical support services. MATES Case Managers are social workers and overseen by the Australian Association of Social Workers practice standards.[427]

MATES described how lived experience drives its Connector and Applied Suicide Intervention Training support programs:

> Individual workers taking the initiative to train in worlds best practice to support colleagues experiencing either a mental health challenge or thoughts of suicide more often than not have lived experience themselves or through a colleague's challenges of mental ill-health and or suicide.[428]

MATES reported that in the last 6 months, 300 new clients were case managed by MATES. Of these cases:

> …the concerns of the person seeking support 60% related to 'relationship' such as relationship breakdown, relationship stress, and associated distress. Physical and mental health challenges were identified at 52% and 'work' related issues such as pressure, stress and bullying at 26%. Of these clients 14% had been directly impacted by the suicide of either a colleague or family member.[429]

5.5.11.2 First responders

The committee heard that suicide risk is increased for people working as first responders[430] due to the nature of their work.[431] Stand Tall for PTS told the committee:

> Our first responders work at the direction of the state governments. All of them are at risk of PTSD because their jobs increase that risk. That means governments must take responsibility for addressing the impacts on their employees.[432]

According to the QPS:

> More than one in 2.5 first responder employees have been diagnosed with a mental health condition in their life compared to one in five of all adults in Australia. The mental health challenges faced by law enforcement have likely been compounded by the substantial changes to, and expansion of, many

425 Submission 113, pp 1-2.

426 Submission 97, p 1.

427 Submission 97, p 2.

428 Submission 97, p 5.

429 Submission 97, p 2.

430 'First responders' are defined in s 36EB(a) of the *Workers' Compensation and Rehabilitation and Other Legislation Amendment Act 2021*, specifically the occupations or professions mentioned in schedule 6A.

431 Lived Experience Australia, submission 12, p 6; see also Roses in the Ocean, public hearing transcript, Brisbane, 18 February 2022, p 14.

432 Stand Tall for PTS, public hearing transcript, Brisbane, p 6.

> policing functions, roles and responsibilities in responding to COVID-19, as well as fatigue and the prospect of infection in the course of duties.[433]

In relation to employee support for first responders, the QPS submitted that it is currently developing a rigorous suicide management framework. The framework is intended to 'address the three key areas of suicide prevention, suicide intervention and suicide postvention and link to the employee lifecycle'.[434]

On 28 April 2021 the QPS launched the Queensland Police Service *Wellbeing Strategy 2021-2024*, which sets a wellbeing vision for the organisation: 'a thriving workforce where our people realise their full potential'. The QPS added that one of the key levers of its *Wellbeing Strategy 2021-2024* is a commitment to improving employee wellbeing at all stages of the career. The QPS advised:

> The Strategy promotes continuous improvement and evidence-based approaches regarding various stages of the employee lifecycle (recruitment, in service, transition out or post-service) by delivering integration and transition programs focusing on mental, physical and social wellbeing. Ensuring a shared responsibility, this will be undertaken with involvement of families in the promotion of wellbeing and education activities to facilitate a broader support system for employees.[435]

The QMHC advised that in recent years the Office of Industrial Relations (in the Department of Education) has led contemporary and innovative processes that align with and extend the workplace mental health recommendations of the Productivity Commission's inquiry, including, 'a new streamlined pathway for first responders and other eligible employees pursing a workers' compensation claim for post-traumatic stress disorder'.[436]

5.5.11.3 Small business owners

When in Bundaberg, one stakeholder spoke of the impact of 'situational stress' on small business owners:

> There is a lot of stress in running your own business … but what we have seen over the last couple of years is an increase in that stress through various measures that we have undertaken to minimise the impact of COVID. We have seen that a lot of the things that were then compounded on top of that increased the stress for business owners because a lot of things were out of their control. …the situational stress seems to come these days from things that are more outside of their control—decisions made by government and so on and so forth which we have no real control around. We are hearing that in order to combat that, we need people to be involved in solutions to rectify that. We need to give them the tools to be able to deal with the stress to be able to manage it effectively.[437]

The committee was advised of local education programs working to respond to situational stress experienced by small business owners in regional communities:

> I will give you a good example: in Kingaroy, the chamber of commerce down there has been working with a variety of groups on the ground to actually train business owners what to look for in their own staff and how to go about managing their own stress levels and so forth.[438]

When in Kingaroy, the committee learned more about the Kingaroy Chamber of Commerce and Industry's (KCCI) 'SMILE' (*Supporting Mental Health through Information – Leadership – Education*) program, which is delivered in partnership with Bunyarra Mediation and Counselling.[439]

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433 Submission 82, p 10.

434 Submission 82, pp 13-14.

435 Submission 82, pp 13-14.

436 Submission 151, p 82.

437 Public hearing transcript, Bundaberg, 7 March 2022, p 2; see also submission 2.

438 Public hearing transcript, Bundaberg, 7 March 2022, p 2.

439 Bunyarra Counselling and Mediation, public hearing transcript, Kingaroy, 20 April 2022, p 15.

Mr Michael Sandford, Counsellor, Principal Practitioner and Director of Bunyarra Mediation and Counselling, explained the program's development:

> A staff member who had tried to access EAP [employee assistance program] was put on a waitlist and unfortunately took their life before the EAP called them back. The chamber approached me at that time and said, 'We need to look at making a change. Tell us about what you're doing. How can we look at implementing that?' …
>
> What I can safely say is we launched a program called Smile at the start of last year which the family who lost their son is an ambassador for. They came along. As part of that we had over 100 businesses attend our initial launch for that practice. We have since been able to roll out education across all of these businesses around what is mental health? What is wellbeing? How do we respond to it? Where are the supports? What happens when critical incidents still occur? The uptake has been phenomenal because it is not just about education: it is about where do we go when things do not go right; being able to provide that resource to business owners around who to call and what to do.
>
> Ultimately, it has saved lives. I can tell you right now that for one company alone we have done five suicide interventions where there was a plan and everything in place for that afternoon. That is just one company. Across all the broader companies in this area I cannot even begin to fathom how much work we are doing. Traditionally EAP for us is like parking an ambulance at the bottom of the cliff. They respond when the incident has occurred. The current system out here is not resourced to handle the uptake of the mental health challenges we face on a daily basis. This is about developing strategies we can target in a community capacity to try to achieve an outcome before we even get to the edge. It is about removing that cliff altogether and having that pro-active response.[440]

5.5.11.4 Bereavement leave

One submitter raised the issue of bereavement leave, particularly for parents who have experienced the death of a child. Mr David Murray told the committee that following the loss of his son Ewan, he and his wife were not dealt with appropriately by their respective employers.[441]

Mr Murray states that the 2 days bereavement leave offered under the National Employment Standards is far too short for parents who have experienced the loss of a child. His submission also advocates for better communication between state institutions and grieving families.[442]

Mr Murray described his experience as follows:

> Though not a technical term I would liken his to an extreme "mental injury" which leaves wounded individuals emotionally distraught, cognitively debilitated and completely disorientated. This state is slowly absorbed into your life. This comes with the price of changing fundamental aspects of your personality and relationships with the people you are closest to.[443]

Committee comment

The committee notes the Queensland Government's *Skilling Queenslanders for Work* program administered by the Department of Employment, Small Business and Training funds training and support for unemployed or underemployed people, with a focus on young people (including those in and transitioned from out-of-home care), Aboriginal and Torres Strait Islander peoples, people with disability, mature-age jobseekers, women re-entering the workforce, veterans and ex-service personnel, and people from culturally and linguistically diverse backgrounds.[444]

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440 Bunyarra Counselling and Mediation, public hearing transcript, Kingaroy, 20 April 2022, p 15.

441 Submission 19, p 1.

442 Submission 19, pp 1-2.

443 Submission 19, p 1.

444 Queensland Government, Department of Employment, Small Business and Training, 'Skilling Queenslanders for Work', https://desbt.qld.gov.au/training/training-careers/incentives/sqw.

The committee has heard there is a need for specific mental health funding to assist people experiencing mental ill-health and alcohol and other drugs issues into employment, as this cohort requires a range of employment programs, flexible timeframes and flexible support in order to succeed in employment.[445]

The committee heard of the greater risk of poor mental ill-health facing Queensland's first responders due to the type of work and the situations within which they work. The committee is encouraged by existing efforts to support first responders, including, for example, the new pathways for first responders to pursue a workers' compensation claim for post-traumatic stress disorder enacted in the *Workers' Compensation and Rehabilitation and Other Legislation Amendment Act 2021* and the QPS's *Wellbeing Strategy 2021-2024*, which seeks to support its first responders at all stages of the employee lifecycle, including post-service. The committee is encouraged by these initiatives but considers that more should be done for first responders when they are no longer employed by the Queensland Government.

The committee heard of the need for greater mental health and wellbeing support in workplaces, particularly for small business owners and in regional communities. The committee also notes the impact that tragic life events can have on someone's ability to work.

The committee has heard of the benefits of workplace support models that are sector specific, such as MATES in Construction, and of community-led programs, such as the KCCI's *SMILE* program, that are educating and supporting the community.

The committee notes that the KCCI has now partnered with the Chamber of Commerce and Industry Queensland, the QMHC, and the Small Business Commissioner's office to create a network for the *SMILE* program, which includes 'walk-and-talk' groups and mentor programs.[446]

The committee notes the Queensland Government's announcement of its *Small Business Support and Wellness Package* which includes an extension of KCCI's *SMILE* program that will see the program activated in more chambers of commerce in Queensland.[447] It is the committee's view that this program should be expanded further with a particular focus on support for small business owners.

445 Stepping Stone Clubhouse, public hearing transcript, Brisbane, 27 January 2022, p 3.

446 Kingaroy Chamber of Commerce and Industry, public hearing transcript, Kingaroy, 20 April 2022, p 17.

447 Minister for Employment and Small Business and Minister for Training and Skills Development, Hon Di Farmer, '*$6.75m mental health and wellness package to mark start of Queensland Small Business Month*', media statement, 30 April 2022.

Recommendation 16 – Expand employment opportunities for people experiencing mental ill-health and alcohol and other drugs issues

The committee recommends the Queensland Government:

a) investigates ways to expand employment support programs such as *Skilling Queenslanders for Work* that are responsive to the needs of people experiencing mental ill-health and alcohol and other drugs issues, including implementing transitional employment programs similar to services provided by the Stepping Stone Clubhouse.

b) works with the Australian Government to identify ways to improve employment programs currently being delivered by the Australian Government.

Recommendation 17 – Improve workplace mental health

The committee recommends the Queensland Government:

a) consults with relevant stakeholders to investigate a mechanism or body to monitor, assist and deliver mental health services to Queensland Government employed first responders post-separation from the workplace.

b) expands workplace suicide prevention programs, particularly for small business, including continuing to expand the Kingaroy Chamber of Commerce and Industry's *SMILE* program across chambers of commerce in Queensland.

c) investigates the viability of expanding the MATES in Construction model, or similar, to other industries such as health and ambulance services, Queensland Police Service, Queensland Fire and Emergency Services, and frontline workers in sectors including, but not limited to, child safety, community services, domestic and family violence, aged care, disability care, hospitality, retail, and transport/logistics.

d) investigates and implements ways to provide greater flexibility to people accessing workplace bereavement leave entitlements, including transition back to work planning.

6 Mental healthcare continuum

As set out in Chapter 4, the funding and regulation of mental health services in Australia is a shared responsibility between the Australian and state and territory governments.[448] This chapter considers the challenges facing the continuum of mental healthcare in Queensland, acknowledging that 'distortionary funding arrangements and unclear government responsibilities' impact on mental health service delivery.[449]

Queensland Health described the mental healthcare continuum as a comprehensive MHAOD system that includes:

- population based universal services, including promotion and prevention
- services responding to individuals, including:
    - primary health care (eg general practice and allied health)
    - specialised care (eg hospital and community bed-based treatment and support services and community treatment and support).[450]

Delivery of this care takes place within a broader system that includes other public, private and non-government services and within a complex legislative, policy, planning, commissioning and funding environment.[451]

6.1.1 Population-based universal services

Many interconnected factors will impact a person's mental health both positively and negatively with risks to mental health being influenced by a person's stage in life, social setting, and personal history.[452]

Population-based programs provide universal and targeted promotion, prevention and harm minimisation approaches.[453] These services focus on promoting the health and wellbeing of all Queenslanders at a population level, across life stages and for specific groups, including enhancing:

- social and emotional wellbeing and improving quality of life
- multi-level responses delivered in partnerships in health, community, workplace and educational settings
- increasing protective factors and reducing risk factors.[454]

Promotion and prevention programs and services also aim to address 'other social determinants of health including inequity, stigma and discrimination, environmental and socio-cultural factors, including exposure to trauma and violence'.[455]

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448 Parliament of Australia, Department of Parliamentary Services, *Mental health in Australia: a quick guide*, Research Paper Series, 2018-19, 14 February 2019, p 3.

449 Productivity Commission, *Mental health inquiry report,* No. 95, 2020, vol 3, p 1133.

450 Queensland Health, *Connecting care to recover 2016-2021. A plan for Queensland's State-funded mental health, alcohol and other drug services*, p 10.

451 Queensland Health, public briefing transcript, 20 January 2022, p 2.

452 Productivity Commission, *Mental Health*, inquiry report, 2020, no. 95, vol 1, p 91.

453 Queensland Health, public briefing transcript, 20 January 2022, p 2.

454 Queensland Health, *Connecting care to recover 2016-2021. A plan for Queensland's State-funded mental health, alcohol and other drug services*, p 10.

455 Queensland Health, *Connecting care to recover 2016-2021. A plan for Queensland's State-funded mental health, alcohol and other drug services*, p 10.

6.1.2 Primary health care

General practitioners and allied health professionals are often the first point of contact for people at risk of or experiencing mild, moderate and even severe mental illness. Primary health care provides:

- low intensity mental health services and early intervention approaches for those experiencing or at risk of mild mental illness
- psychological and physical clinical care and care coordination for those experiencing moderate, severe and complex mental illness.[456]

6.1.3 Specialised care services responding to individuals

State-funded MHAOD services responding to individuals delivered by HHSs and NGOs are provided across the following 6 key categories:

- **Community treatment services** – delivered through a range of assessment, treatment, and rehabilitation services within the community, eg Acute Care Teams, Clinical Community Treatment Teams, and Mobile Intensive Rehabilitation Teams. Key community-based AOD treatment services include psychological intervention (counselling), non-residential rehabilitation, assessment, withdrawal management and harm reduction, education and information.
- **Community support services** – deliver a range of services to support individuals to stay connected to their community, including programs to assist in meeting recovery goals, maintaining social and economic wellbeing and providing early intervention, harm reduction and information, education and peer support. Delivered by NGOs in collaboration with HHSs.
- **Community bed based services** – deliver ongoing care and support in a community residential setting through Community Care Units, Step Up Step Down Units and residential rehabilitation units. This type of care can be delivered in partnership with NGOs and provides short to medium to long-term recovery orientated treatment for individuals.
- **Hospital bed based services** – deliver specialist care to individuals who cannot be adequately treated in the community setting. Delivered through mental health inpatient units, secure mental health rehabilitation units, and acute and non-acute (extended treatment) older persons bed-based mental health services. AOD withdrawal management and care is delivered in a hospital bed-based setting where appropriate.
- **Crisis response services** – deliver short-term clinical support and stabilisation to individuals experiencing a mental health crisis that may involve alcohol and other drugs. Delivered through tele-triage services (1300 MH CALL), emergency departments and acute care teams, co-responder models, crisis support spaces and crisis stabilisation services.
- **Specialised services** – tailored interventions by specialist staff and multidisciplinary teams to priority groups through HHSs or another agency/organisation. Services include forensic services, perinatal and infant services, eating disorder services, specialised AOD services tailored to address the needs of people involved in, or referred from, the criminal justice system and the delivery of opioid substitutional treatment in correctional facilities.[457]

[456] Queensland Health, briefing paper, 1 February 2022, p 8.

[457] Queensland Health, briefing paper, 1 February 2022, p 11.

Queensland Health advised that 'these categories align to the evidence-based treatment and care continuum for individuals who may require some or all of these elements of treatment and support during the course of their illness and recovery'.[458]

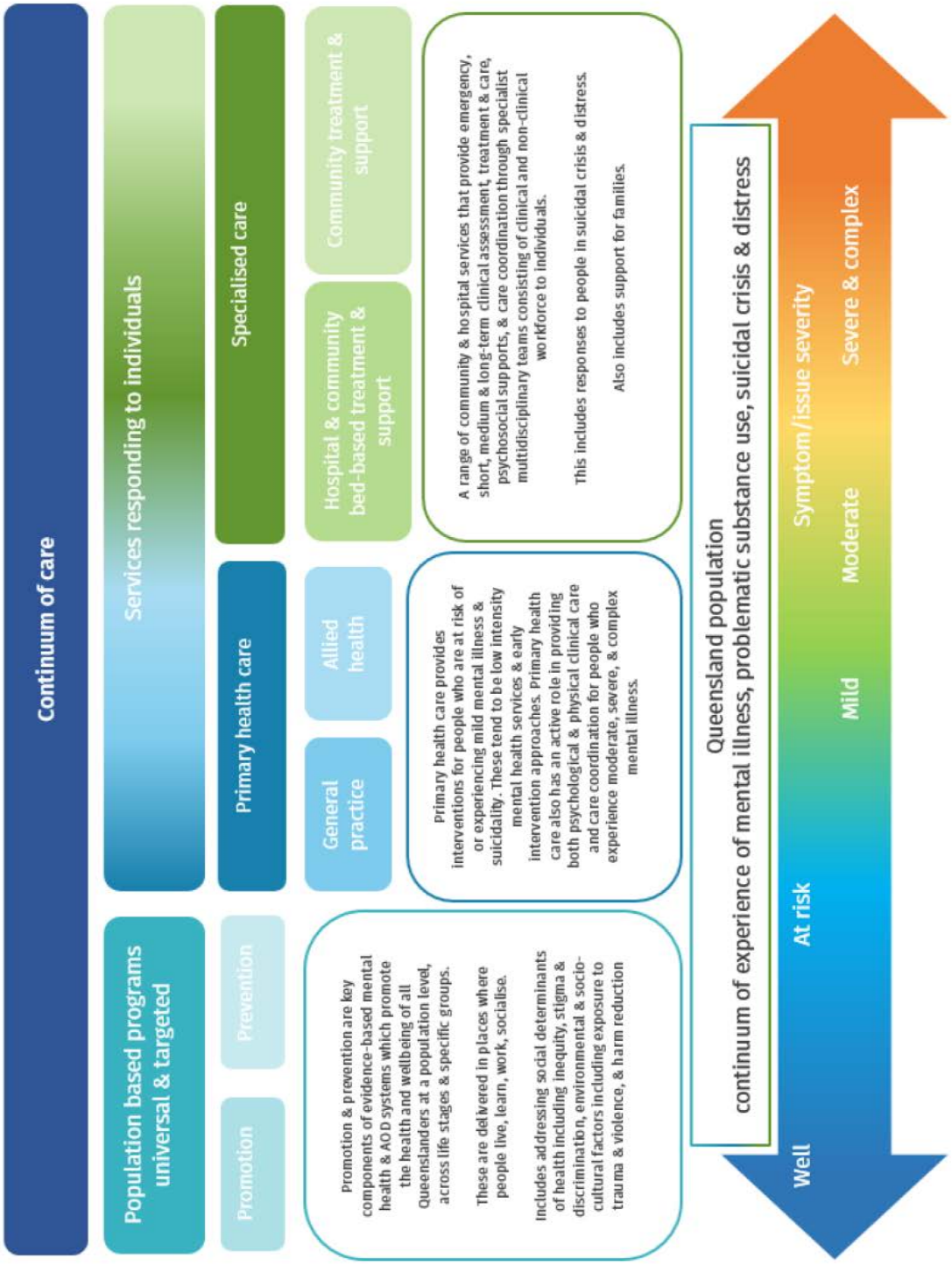

Figure 4 - High level overview of continuum of care[459]

458 Queensland Health, briefing paper, 1 February 2022, p 11.

459 Queensland Health, briefing paper, 1 February 2022, p 8.

6.2 Challenges to the mental health and AOD service system

During its inquiry, the committee heard about various challenges of delivering services across the continuum of care, including the need for more services generally, improved service coordination and integration, and increased service provision to rural, regional areas and remote areas. This chapter explores these issues and others as they relate to the mental health care continuum.

6.2.1 The 'missing middle'

The 'missing middle' refers to the proportion of the community experiencing moderate mental ill-health for whom there is a lack of services in particular because the current system focuses on the mild and acute ends.[460]

Queensland Health explained:

> The 'missing middle' is sort of defined as those people who are too sick just for their GP to handle but not sick enough to come into the publicly funded mental health service, except by crisis usually, to go into ongoing treatment. I think it is a bit of a bad definition because it talks about the patient's problems rather than the system's problems. Geography, your income, the availability of services and capacity—health literacy and so on—actually make a big difference to how big the gap is and where you fit. Obviously the gap is different for a person in Brisbane who has resources than for a person in Mount Isa who does not have any resources, for example.[461]

There are approximately 150,000 Queenslanders who comprise the missing middle.[462]

The Productivity Commission considered that the missing middle 'primarily reflects a lack of community mental health services', and noted that some groups of people, such as Aboriginal and Torres Strait Islander peoples, and people in rural, regional and remote areas are overly represented in the missing middle.[463]

QAMH identified factors that it considered have contributed to the emergence of the missing middle:

- increasing demand against a background of long periods of underinvestment in the mental health system by all levels of government
- a system which is designed around responding to crisis rather than actively supporting wellbeing or responding early in distress
- policy decisions that have channelled funding and resources into supporting specific cohorts, leading to people falling through the gaps in care
- a system which is notoriously difficult for the public to navigate due to service fragmentation and lack of integration within the system
- a lack of innovation and diversity with a narrow focus on clinical services to the exclusion of the community mental health and wellbeing sector
- a lack of consumer confidence in the types of care on offer which are all too often described as traumatising and retraumatising leading to people avoiding the system altogether

[460] Queensland Mental Health Commission, public hearing transcript, Brisbane, 20 January 2022, p 23; Public briefing transcript, 20 January 2022, p 17.

[461] Public briefing transcript, 20 January 2022, p 17.

[462] QMHC, public briefing transcript, Brisbane, 17 February 2022, p 2. See also QMHC, submission 151, p 35, in which it is stated that the missing middle comprise around 18% of the population of people who are unwell.

[463] Productivity Commission, *Mental Health*, inquiry report, 2020, no. 95, vol 1, p 30.

- high out-of-pocket costs associated with GP and psychologist visits, making it too costly for the vast majority of people
- a demarcation in responsibilities between state and federal governments has created a gap in services with no one taking full responsibility for this group of people.[464]

6.2.1.1 Problems arising from a lack of mental health services for the missing middle

The mental health service gap faced by the missing middle often means that people with mental ill-health end up in crisis and attending an emergency department (ED). A report published in 2021 by Lived Experience Australia based on survey responses provided by consumers, families and carers found that:

> Over half of both consumer and carer respondents identified that not being able to access mental health services when needed contributed to the consumer going into crisis. 40% of both consumer and carer respondents could not access mental health services at the point they needed it within a reasonable timeframe. Difficulties accessing mental health support was identified as the main reason for deterioration in mental health and wellbeing leading to crisis.[465]

Anglicare Southern Queensland submitted that system design contributes to the stress on it:

> Focusing almost solely on those with severe and persistent mental ill health creates a system that is reactive, crisis-driven and shaped by a medical model of care. This leaves it without capacity to support either those showing early signs of distress, or people in what the Productivity Commission calls the 'missing middle': those too unwell to be treated in the primary care system but not yet (though very likely to be) sick enough to be treated by acute services.[466]

Certain adolescents and young people, for example, fall into the missing middle, resulting in delayed treatment, their issues becoming more serious, and treatment costing more:

> It is a particular problem for young people because they are falling through the cracks and are having to wait until a crisis. It is not ideal and does not make sense when treatment at the mild to moderate end of the spectrum is more effective and costs far less. All this is happening at a time when you are most likely to develop a mental illness. Suicide is the leading cause of death. The impacts on the young person's educational, developmental, employment and social trajectories can be devastating.[467]

The gap in services faced by the missing middle has also reportedly contributed to an over-reliance on medication as the main, or sometimes the only, treatment for a population who could be better served by other options.[468]

The Queensland Mental Health Commissioner was of the view that, within the current funding arrangements, services for the missing middle should be funded by the Australian Government:

> … For hospital, clinical and severe the responsibility is clearly on the state government and the Queensland Health system. Having said that, I see all of the other parts being the responsibility of the federal government. That is my opinion. I see that as a responsibility of the federal government, unless things change. At the moment, they are the lanes we operate in.[469]

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464 Submission 119, p 13.

465 Lived Experience Australia, *The 'missing middle' lived experience perspectives*, 2021, https://www.livedexperienceaustralia.com.au/research-missingmiddle, p 3.

466 Anglicare Southern Queensland, submission 41, p 6.

467 Mater Young Adult Health Centre, public hearing transcript, Brisbane, 11 February 2022, p 10.

468 Submission 151, p 7.

469 Public briefing transcript, Brisbane, 20 January 2022, p 30.

6.2.1.2 Lack of service coordination and integration

The QMHC stated that the mental health landscape is 'characterised by fragmentation, limited integration within and across other areas of essential non-mental service provision, with ill-defined pathways between levels of care and services, duplication, and siloed approaches'.[470]

headspace reported that major reviews of Australian mental health systems at the national and state levels report that systems and services are siloed, fragmented, and hard for clients and even providers to navigate. headspace stated:

> There is both opportunity and need to increase holistic, multi-disciplinary, wrap-around support that responds to individuals' needs and circumstances across ages and stages of life – ensuring people can access the right support, when they need it and how they want it.[471]

Creating Liveable Communities stated that one of the main challenges in communities is the 'lack of continuity in terms of mental health care, services and communication across the different operational areas'. This 'disjointed service provision' means that the same access to support is not always seen, and communication between the different service areas does not provide a person-centred continuum of care.[472]

Queensland Health recognised the impact of a health system that does not provide an integrated model of care on mental health (MH):

> There is growing consensus internationally that we need MH crisis reform to move away from siloed, piecemeal responses which maintain fragmented, highly variable and frequently costly responses, to focus on the whole crisis system of care.[473]

The Queensland Centre for Perinatal and Infant Mental Health (QCPIMH) commented on the need to provide services locally:

> You have also heard about fragmentation, silos and poor integration. We lack a systematic and sustained approach to service implementation and integration close to the places and communities where families live in order to create the continuum of care across sectors that we need. You have no doubt heard the saying 'it takes a whole village to raise a child.' Our challenge is to create that village for Queensland in an integrated, holistic and sustainable way, at an agency and system level, at a service level and at the place based community village level across a vast and varied state. We all have a role to play. Relationships with families and each other are the key. We have to create opportunities and investments to work, plan and develop a service system together.[474]

Open Minds Australia Ltd stated that providing high-quality services for young people and the missing middle requires strong state and NGO collaboration. Open Minds Australia Ltd explained:

> While some headspace centres find collaboration with the HHSs, CYMHS [Child and Youth Mental Health Services] and AOD services challenging, there are examples of strong relationships and localised agreements with state health services. For example, I work with Children's Health Queensland to co-locate CYMHS services at two of our centres. This was a great outcome; however, it took three years of negotiation and only happened because key staff in Children's Health Queensland and our organisation wanted to see it happen. In my view, there is a need to have a more formalised working relationship between headspace centres and state health services so we do not spend three years negotiating a service level agreement to co-locate staff.[475]

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470 Queensland Mental Health Commission, briefing paper, 20 January 2022, p 2.

471 Submission 66, p 5.

472 Submission 78, p 4.

473 Submission 150, p 81.

474 Public hearing transcript, Brisbane, 11 February 2022, p 20.

475 Public hearing transcript, Brisbane, 10 March 2022, p 8.

headspace similarly recommended better integration of supports and services to address the young people in the missing middle.[476]

Queensland Health identified collaboration with PHNs as helpful to addressing the problems facing the missing middle:

> One is the joint work that we do with PHNs to try to identify particular cohorts that need to be given a good filter and a good gateway before they get into the crisis and before they get into our system. The other is about early identification—for example, GPs being able to use the plans and services that are available to them to get the right people into that early treatment, to get their depression treated and so on.[477]

6.2.1.3 Wait times

In discussing the missing middle, some stakeholders noted the long wait times to see mental health specialists, such as GPs, psychologists and psychiatrists, and the potential negative impact that a lack of early intervention and prevention can have on someone's mental health and wellbeing.[478] Stakeholders generally supported an increase in services to decrease wait times. Submitter, Ms Pattison also recommended 'upskilling and training more peer support workers and funding peer support services'.[479]

6.2.2 Psychosocial disability

Psychosocial disability is a term used to describe a disability that may arise from a mental health issue. Under the NDIS, not everyone who has a mental health condition will have a psychosocial disability, but for people who do, it can be severe, longstanding and impact on their recovery. People with a disability as a result of their mental health condition may qualify for the NDIS.[480]

Witnesses before the committee discussed whether the NDIS is fit for purpose for mental health.[481]

GROW Australia explained:

> What can be more stigmatising than saying to someone, 'You have a permanent disability in mental illness'? The NDIS does not fit that model very well for the mental system. We know that. Mental ill health was added on as the last option in relation to the NDIS. It does not fit a recovery model all that well: 'You are going to keep your package as long as you are deemed to have a permanent disability.'[482]

GROW Australia added that with the way the fee-for-service model works for the NDIS, you are only able to charge while you are supporting that person. According to GROW Australia:

> It really robs them of their ability to self-activate for their own recovery. If we have a setback we always encourage people to go and talk to their GP about the program or to support each other. They are doing that independently of us. They are always building those skill sets if they want to go back to work or

476 Submission 66, p 14.

477 Queensland Health, public briefing transcript, Brisbane, 20 January 2022, pp 17-18.

478 Mater Young Adult Health Centre, public hearing transcript, Brisbane, 11 February 2022, p 10; Wide Bay Hospital and Health Service, public hearing transcript, Bundaberg, p 15; QPASTT, public hearing transcript, Brisbane, 11 March 2022, p 47; Australian Association of Psychologists, public hearing transcript, Brisbane, 10 March 2022, p 64; headspace, public hearing transcript, 20 January 2022, p 34; Independent Schools Queensland, public hearing transcript, Brisbane, 11 February 2022, p 2.

479 Submission 159, p 5.

480 National Disability Insurance Scheme, 'Mental health and the NDIS': www.ndis.gov.au/understanding/how-ndis-works/mental-health-and-ndis#new-psychosocial-recovery-oriented-framework.

481 See, for example, public hearing transcript, Brisbane, 13 April pp 19-26.

482 Public hearing transcript, Brisbane, 13 April 2022, p 24.

> whatever the case may be. However, if you are only funded when you are with the person you kind of rob them of a lot of ability to be instrumental in their own recovery.[483]

QAMH explained that the NDIS 'did not really take into account the episodic nature' of mental illness:

> I am sure you have heard people talk about how that was not fit for purpose for mental health. It was a disability initiative and really did not take into account the episodic nature that you might have with mental illness.[484]

The Mental Illness Fellowship Australia (MIFA) told the committee of the need to shift the focus in NDIS service delivery to celebrate recovery and success:

> MIFA has been working with the NDIA [National Disability Insurance Agency] and others on the advisory committee that has been implementing the recovery framework for the NDIS. We are very hopeful that under this new recovery framework for psychosocial disability we will see a shift in the way that psychosocial supports are managed within the NDIS. Right now people are really fearful that if they get better they will experience incredible cuts to their packages or they will completely lose their package. We have a lot of work to do in shifting that focus around celebrating recovery and celebrating success so that people are not so afraid of actually getting better.[485]

Another issue that was raised related to the impact of the NDIS and the lack of coordination of services. In this regard, Professor Scott of the QIMR Berghofer Medical Research Institute:

> … what that [the NDIS] has done is take funding away from services that did provide integrated care and give funding to families and consumers who then purchase in their care. But the care providers do not talk to each other, so the care that gets delivered is not coordinated, it is often ineffective and it does not make a difference. What I see very commonly in my clinical practice is people saying, 'I have a psychologist, an occupational therapist and a speech therapist coming in weekly to look after me.' I say, 'What do they do?' They say, 'I don't know what they do. I don't know, but I have to spend my money so I get them coming in,' whereas previously care would have been provided for people and it would have been coordinated. There would be some clinical governance—some clinical oversight—saying, 'This is what this person needs.' Now it is just these packages of care coming in so the funds get spent. That is not the case for everyone, but it is for a lot of people.[486]

Committee comment

The committee has heard evidence that the NDIS does not take into account the episodic nature of mental illness, and that the model of service delivery removes a person's 'ability to self-activate' for their own recovery.[487] In light of the evidence, it is the committee's view that the Queensland and Australian Governments should work together to ensure the NDIS is supporting people to become empowered and independent with individuals driving their selection of services.

The committee notes the release of the NDIS recovery framework, *National Disability Insurance Scheme Psychosocial Disability Recovery-Oriented Framework,* to improve the responsiveness of the NDIS to people living with psychosocial disability.

The committee encourages the Queensland Government to work with the Australian Government to ensure the NDIS delivers a system for people experiencing mental ill-health that empowers individuals to maximise their independence and is responsive to the episodic nature of mental ill-health.

483 Public hearing transcript, Brisbane, 13 April 2022, p 25.

484 Public hearing transcript, Brisbane, 10 March 2022, p 24.

485 Public hearing transcript, Brisbane, 13 April 2022, p 25.

486 QIMR Berghofer Medical Research Institute, public hearing transcript, 11 February 2022, p 18.

487 Public hearing transcript, Brisbane, 13 April 2022, p 25.

Several stakeholders noted that Head to Health centres address some of the issues that are contributing to the missing middle. See section 6.4.2.4 for more information about Head to Health centres.

6.3 Creating a person-centred mental health system

Many submitters supported the importance of a person-centred approach to mental health and wellbeing that ensures people who access services are at the centre of planning and decision-making.[488]

Anglicare Southern Queensland stated this would empower people to choose the services that are right for them 'across a full spectrum of clinical and non-clinical needs'.[489] Similarly, in its report, the Productivity Commission stated that 'a person-centred mental health system should empower people to choose the services that are suitable to them, and focus on their recovery'.[490]

The Brisbane South PHN stated that person-centred care meant that 'consumers will shape how, when and where we deliver services'.[491] The Australian College of Mental Health Nurses (ACMHN) contended that a person-centred delivery system would mean that people have the right support at the right time, resulting in mental health care that is 'fully integrated into our health system, across the care continuum from prevention, crisis response, harm reduction, treatment and recovery'.[492]

The Productivity Commission outlined the issues with the current system:

> … in the current system, people with mental ill-health often cannot access the services that are right for them — either because they are not available, or because there are a range of barriers that prevent access. To achieve a person-centred mental health system, governments would need to work towards expanding the availability of some services (such as supported online treatment and community ambulatory services) and improving the accessibility of others ...[493]

Recommendations in the Productivity Commission report focused on making the mental health system easier to access and use, as well as more effective in linking people to the services that are most suitable to their needs.[494]

The committee notes the Stepped Care Model which is central to the Australian Government's mental health reform agenda. The programs delivered by PHNs for mental healthcare follow and advocate a stepped care approach, which is a staged approach to mental health services, delivering care across the range of mental illness needs.[495] Stepped care is defined as an evidence-based, staged system comprising a hierarchy of interventions from the least to the most intensive, matched to the individual's needs. The intention of the stepped-care model is for individuals to receive different methods and forms of care matched to the severity of their mental illness, providing a holistic approach to services across the spectrum of need.[496]

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488 See, for example, submissions 3, 87, 92, 93, 102, 107, 112, 115, 123, 125, 126, 137, 140, 150, 151, and 155.

489 Submission 41, p 32.

490 Productivity Commission, *Mental Health*, inquiry report, 2020, no. 95, vol 1, p 183.

491 Submission 87, p 7.

492 Submission 115, p 9.

493 Productivity Commission, *Mental Health*, inquiry report, 2020, no. 95, vol 1, p 183.

494 Productivity Commission, *Mental Health*, inquiry report, 2020, no. 95, vol 1.

495 Primary Health Networks Queensland, submission 107, p 3; Northern Queensland PHN, Mental Health, https://www.nqphn.com.au/healthcare-professional/resource-library/mental-health.

496 Primary Health Networks Queensland, submission 107, p 3; Northern Queensland PHN, Mental Health, https://www.nqphn.com.au/healthcare-professional/resource-library/mental-health.

Another model of care seeking to meet individuals where they are at on the mental health continuum is 'step up, step down' services. According to the Productivity Commission, step up, step down services are:

> … provided to people who have recently experienced or who are at increasing risk of experiencing an acute episode of mental illness. The person usually requires higher intensity treatment and care to reduce symptoms and/or distress that cannot be adequately provided in the person's home but does not require the treatment intensity provided by an acute inpatient unit. People may access these services by:
>
> - 'stepping down' from a period of treatment in an acute inpatient unit to allow continued treatment in a supportive environment aimed at achieving further symptom reduction and recovery from the acute episode
> - 'stepping up' from the community when experiencing an increase in symptoms/distress to receive treatment in a supportive environment designed to prevent further deterioration and avoiding a hospital admission.[497]

In relation to stepping up and stepping down on this model of care, Professor Dan Siskind explained further:

> Let's say you have had some increase in suicidal ideation and you are in the community. You need somewhere to be safe, away from other people who might be using or are a bad influence. The model provides residential support services that are not quite as intensive as a hospital to give people that area of safety and space. There is a nice one that runs down in Logan called Acmena House, which is a lovely model of this. Then for stepping down, just say you have someone who has had an acute hospitalisation. They may need a little bit more time to get their medication sorted out or maybe they are not quite ready to go home independently where they have to clean the fridge, deal with the mess in their place, organise their shopping and organise their cooking. It gives them a few extra days to get a bit more stable before they go there. Stepping up is from within the community, providing a slightly more supportive place; stepping down is from the inpatient psychiatric hospital. We did some evaluations of these services in Queensland: they save you money and they keep people out of hospital, so they are very cost effective.[498]

6.3.1 Recommendations for person-centred care

Queensland Health stated that it contributes to a person-centred system through 'the provision of specialist MHAOD treatment, care and support and more broadly through the EDs along with other health responses'.[499]

The Brisbane South PHN recommended the following was required in order to design a person-centred mental health system:

- HHSs should have the flexibility to co-design and co-commission initiatives that support integrated care pathways and place-based responses to the unique needs of their region
- increase the availability of and access to family based supports and access to child and youth psychosocial support in the community, ensuring they are integrated with Child and Youth Mental Health Services and headspace to enable smooth transitions as the needs of the young people and family change
- consider the implications of transitioning from childhood to adulthood in the healthcare system and how patients can be better supported through this transition
- prioritise prevention, early intervention and mental health wellbeing responses focused on children and their families from the perinatal period

497 Productivity Commission, *Mental Health*, inquiry report, 2020, no. 95, vol 1, p 594.

498 Public hearing transcript, Brisbane, 11 February 2022, p 25.

499 Submission 150, p 15.

- co-design and implement peer-led perinatal mental health supports
- provide wraparound service responses for young people by integrating referral pathways across primary care, tertiary mental health services and specialist services.[500]

Micah Projects recommended that a trauma-informed approach to the provision of integrated and holistic care be adopted, both within Queensland Health and in the investment into community-based services.[501]

6.3.2 Targeting populations at greater risk of mental ill-health

The committee also heard of the need for a mental healthcare system that is responsive to the needs of populations that are at greater risk of mental ill-health. The Mental Health Commissioner noted that the strain on the mental healthcare system has reduced capacity to address the needs of specific at-risk groups:

> Over time the service system has been required to raise its access threshold … to ensure support to those most in need. Unfortunately, this means that people are turned away until they are in significant distress or absolute crisis. Alternatively, we regularly hear that services largely offer assessment and triage, with referral becoming the de facto intervention. This also means there is limited scope to address the specific needs of at-risk communities such as our Aboriginal and Torres Strait Islander people, LGBTI people but also people from culturally and linguistically diverse backgrounds.[502]

Committee comment

Sections 5.3 and 5.5 of this report provide that a range of social determinants of health, including belonging to particular groups in society, can increase the risk of experiencing mental ill-health. The committee notes that a person-centred system requires capacity to be responsive to the needs of people at greater risk. A number of recommendations made in section 5.5 and in this chapter are directed toward improving the responsiveness of Queensland's mental healthcare system to at-risk groups.

6.3.3 Mental health promotion and early intervention

Stakeholders stated that promoting wellbeing and early intervention were key to maintaining mental health wellbeing, with some stakeholders calling for a focus on community-based services to address the gaps in mental health services faced by the missing middle.[503]

The QMHC considered that the mental health system is 'largely imbalanced to late intervention which is harmful for the individual and significantly costly to service those systems and governments'. The QHMC stated:

> Unintentionally—and I say unintentionally—we have established a hospital-centric service system where the emergency department has become the front door of all mental health care. As a result we have a system that focuses on system management, treatment and intervention and not one focused on population mental health and wellbeing.[504]

The Commissioner submitted that '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'.[505] He argued that outside of the NDIS, investment in the community mental health sector to provide non-clinical psychosocial support

500 Submission 87, p 4.

501 Submission 131, p 26.

502 Public hearing transcript, Brisbane, 20 January 2022, p 23.

503 See, for example, submission 73.

504 Public hearing transcript, Brisbane, 20 January 2022, p 23.

505 Submission 151, p 3.

is inadequate to need, leading to a greater dependence on hospital-based services and services funded through the MBS.[506]

The QMHC contended that an optimally functioning mental health system 'can only occur within a broader population mental health approach'. A population mental health approach, establishes mental health as a whole-of-community issue, recognising the importance of attending to the whole population's mental health and wellbeing needs. [507] According to the QMHC, this includes:

- supporting and protecting the mental health and wellbeing of all Queenslanders
- identifying and responding to individuals and groups at greater risk of mental health problems due to individual, social, economic, cultural and environmental circumstances
- ensuring people with lived experience of mental health challenges and illness can live lives with purpose and equality, supported through quality, person-centred and holistic mental health support and interventions while maintaining social and economic participation.[508]

The QMHC further stated:

> A population mental health approach also points to the shared responsibilities across sectors to support and protect the mental health of the population. This includes the responsibility to detect and respond to the needs of people at risk of, or living with, mental health challenges or illness.
>
> In this regard, the mental health sector, including public, private, primary health and non-government sectors, have a critical role in providing a continuum of integrated mental health interventions, support and treatments.
>
> It also requires collaboration across systems and services to ensure all economic, housing, vocational, educational, social and recreational needs are seamlessly provided.[509]

In relation to mental health promotion, Prevention United stated that it is different from, but complementary to mental healthcare, advising that mental health promotion:

> … focuses on modifying the underlying root causes of mental ill-health rather than managing specific conditions. It targets whole groups and communities and is undertaken in a range of settings such as online, the home, schools, workplaces, and neighbourhoods, rather than just through mental health services alone.[510]

Prevention United contended that a robust mental health system needs to include both elements and cover the entire continuum from wellbeing, prevention, early intervention, recovery support and suicide prevention. Prevention United considered that at present, Queensland's response, like most jurisdictions, is heavily skewed towards mental healthcare and stated:

> … this needs to be rebalanced so that more emphasis is put on keeping people well and preventing mental health conditions from occurring in the first place, as well as on continuing to support people's recovery from mental ill-health.[511]

6.3.3.1 Early intervention strategies to address the missing middle

Micah Projects agreed that focus needs to be on a continuum of care 'around prevention and early intervention, integrated housing access, social inclusion' with 'mobile multidisciplinary teams

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506 Queensland Mental Health Commission, briefing paper, 20 January 2022, p 18. Footnotes in original omitted.

507 Queensland Mental Health Commission, briefing paper, 20 January 2022, p 3.

508 Queensland Mental Health Commission, briefing paper, 20 January 2022, p 4.

509 Queensland Mental Health Commission, briefing paper, 20 January 2022, p 4.

510 Submission 114, p 4.

511 Submission 114, p 4.

providing integrated in-home, healthcare, housing and social support across the systems of care that is appropriate to individuals and or families and housing type'.[512]

Anglicare Southern Queensland also highlighted the importance of positioning mental health as a universal concern for all community members, supported by a continuum of services that offers early and easy access, reduces stigma and has the flexibility to address the particular needs of individuals and groups to ensure equity of access and culturally appropriate care.[513]

Professor Whiteford supported the view that, based on evidence, 'early intervention is an effective way of preventing individuals with early mental health problems from progressing to more significant mental health problems'. He continued:

> The issue is really understanding that continuum from risk factors in the community, which fall outside of health departments usually but are an important part of other community services and social services that support families, through to primary care, specialist care, hospital beds et cetera. If you do not get that balance right then a lot of the pressure ends up further down the system in acute care whereas the evidence is that we could have intervened earlier if we had the knowledge about what worked for whom and at what time.[514]

The Wide Bay HHS also pointed to the positive impact that early intervention has on reducing the number of crisis presentations:

> We will continue to have to pick up those crisis presentations in the absence of early intervention and prevention services. We will continue to have to increase the number of our beds unless we put more resourcing into that prevention and early identification. We will constantly be the ambulance at the bottom of the hill waiting for those presentations to occur.[515]

QPASTT expressed concern that they are often 'forced to work at the crisis end of the care continuum, thereby neglecting prevention and early intervention'.[516] QPASTT stated:

> Unfortunately, the need for our services has increased greatly to the point that we currently have a waitlist of almost 500 people. We attempt to triage vulnerability to mitigate risk. However, as a CEO, our waitlist worries me greatly due to the level of clinical risk for people waiting for our support, including children. The experience for us is mirrored across the entire mental health system. By that I mean that the level of acuity needed to quickly access support has increased, meaning that people are no longer able to access early support when their symptoms are less and more manageable.[517]

QAMH submitted that funding should be provided to enable the community sector to assist in addressing the missing middle:

> QAMH believes that the Community Mental Health and Wellbeing Sector should form part of the solution to addressing the missing middle. As an accessible, evidence-based, relatively cost-effective sector, with an ability to be scaled up on demand, it is perfectly positioned to fill this service gap, freeing up the hospital system for more acute presentations. However, this would require a significant restructuring of funding models to an emphasis on supporting community mental health and wellbeing services, redesigning entry points and referral pathways to shift away from GPs and hospitals, and a recognition from governments that not all human distress needs a clinical response.[518]

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512 Submission 131, p 6.

513 Submission 41, p 1.

514 Public hearing transcript, Brisbane, 17 February 2022, p 27.

515 Public hearing transcript, Bundaberg, p 15.

516 Public hearing transcript, Brisbane, 11 March 2022, p 47.

517 Public hearing transcript, Brisbane, 11 March 2022, p 47.

518 Submission 119, p 14.

Wellways Australia and the Queensland Nurses and Midwives' Union (QNMU) agreed with QAMH that the community mental health and wellbeing sector should form part of the solution to addressing services for the missing middle.[519] The QNMU stated:

> I think we need to fundamentally focus on community based services and offering new types of services, multidisciplinary or even nurse-led services within the community. We need to be keeping people away from acute-care facilities that just are not good for people who are acutely unwell. They need to be cared for as close to home as possible.[520]

The Australian Association of Psychologists (AAPi) also supported the idea of a community-based approach to the treatment of people who fall within the missing middle.[521] The AAPi added:

> In our current mental health system, we sort of wait for people to be sick enough, and this is a dynamic that we urgently need to change. We want people to seek support early. We want early intervention and ideally prevention so that they do not escalate to these more acute services. That is very distressing to individuals, families and communities and it is also not cost-effective for the government to help assess. We do need to focus on that early intervention and preventive factor, which we see psychologists playing a very important part in.[522]

Orygen broadly supported funding for not-for-profit community mental health services but submitted that 'it is important that there are sufficient community-based services with clinical expertise, as well as those providing other psychosocial supports'. It considered community-based mental health services provide the best opportunity to address service gaps in rural Queensland.[523]

The IUIH submitted that, with support, it 'can help address unmet need and alleviate some of the burden from the mainstream mental health system, by providing community-based care for Aboriginal and Torres Strait Islander people that fall into both the low acuity and missing middle cohorts'.[524]

The Productivity Commission acknowledged that 'early intervention and prevention would reduce, but not eliminate, mental illness' because 'many people, at some point in their lives, would seek support from mental healthcare services'.[525]

6.3.3.2 Expanding primary healthcare provision

Stakeholders addressed issues relating to primary healthcare, including access to GPs, decreasing wait times, and investment in community-based services.

Brisbane South PHN also recommended the inclusion of a wider range of skills into the primary care of people with mental ill-health:

> I think the process should be established that primary care does not just consist of GPs and allied health professionals. It should be extended to include not only allied health professionals but people with special interests. It should be social workers and, indeed, I suggest people with lived experience, who bring a wealth of experience to this.[526]

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519 Submission 123, p 8; QNMU, public hearing transcript, Brisbane, 10 March 2022, p 48.

520 Public hearing transcript, Brisbane, 10 March 2022, p 48.

521 Public hearing transcript, Brisbane, 10 March 2022, p 64.

522 Public hearing transcript, Brisbane, 10 March 2022, p 64.

523 Submission 73, p 12.

524 Institute for Urban Indigenous Health, submission 137, pp 5-6, 8. NB: in-text referencing removed. Refer to original source for more information.

525 Productivity Commission, Mental Health, inquiry report, 2020, no. 95, vol 1, p 183.

526 Public hearing transcript, Brisbane, 17 February 2022, p 4.

6.3.3.3 General practitioners

To address the gap in services for the missing middle, the AMAQ recommended extra funding for GPs to enable them to spend longer with patients with mental health conditions, and for GPs to be able to work with specialists early in the process so they, along with others such as nurses, can provide care in the community.[527] The Royal Australian College of General Practitioners, Queensland Branch (RACGP Queensland Branch) made similar comments:

> I absolutely think there is a need for MBS reform, if only to encourage collaboration. The biggest risk here is: if we are funding more people to provide care there is fragmented care. There needs to be an incentive for community health providers, whether they be GPs or nurses or psychologists, to collaborate and to meet it better. The current MBS, as you are alluding to, is based on quick throughput. Clinicians are rewarded for seeing more patients. We need more time with patients. Also, non-face-to-face time and collaborations with other health professionals are extremely important in mental health provision.[528]

Refer to section 7.4.3.3 which makes a recommendation concerning Medicare Benefit Scheme rebates.

Other stakeholders also expressed support for incentives for GPs to be able to spend longer with mental health patients.[529]

Queensland Health acknowledged the important role of GPs in the mental health care continuum:

> Access to GPs and general support services, described as primary mental health care, in a stepped model of mental health care is critical. Without this early intervention and care coordination to assist individuals and their families we risk issues, crises and conditions worsening and escalating.[530]

6.3.3.4 Investment in perinatal and infant mental health

Several submitters highlighted the importance of the first 1000 to 2000 days of life 'as the backbone of minimising the economic and societal impact of mental illness in Queensland'.[531] Evidence shows that interventions during this time 'result in significant improvement to children's early life experiences, mental health, and physical development'.[532]

Mater Health – Perinatal Mental Health elaborated:

> Investment in perinatal mental healthcare ensures a reduction in difficulties associated with mother and infant attachment, ongoing mental illness and distress, and can reduce the likelihood of failure to thrive. Children of parents with PND [postnatal depression] are at high risk of lifetime impacts to development, productivity, and wellbeing. There is emerging evidence to suggest that what is learned in the first 1000 days can have a profound impact on not only the neurological system, but also other bodily systems to which the brain is connected. An 'unhealthy' start to life will reduce biological reserves, but this is then overlaid by maladaptive psychological and behavioural responses, and in some instances by enduring unhealthy behaviours. Some of this is impossible to regain.
>
> The consequences over the course of life can be devastating, with evidence suggesting negative impacts for future education and employment opportunities. Children born to a parent who experiences ante-natal depression are at greater risk of experiencing depression later in life, resulting in health and

527 Public hearing transcript, Brisbane, 17 February 2022, pp 10-11.

528 Public hearing transcript, Brisbane, 17 February 2022, p 4.

529 See, for example, Wide Bay Hospital and Health Service, public hearing transcript, Brisbane, 7 March 2022, p 16; Queensland Mental Health Commission, briefing paper, 20 January 2022, p 17.

530 Public hearing transcript, Brisbane, 20 January 2022, p 3.

531 Queensland Mental Health Commission, submission 151, p 48. See also submissions 100 and 102.

532 Peach Tree, submission 102, p 3.

> productivity impacts. Antenatal depression has been associated with increased likelihood of anxiety in children at 18 years of age which has been found to result in an additional $1.3 billion of lifetime costs.[533]

The Queensland Centre for Perinatal and Infant Mental Health (QCPIMH) was established in 2008 by the Department of Health's MHAOD Branch to be a state-wide hub of expertise for the development of a continuum of care in perinatal and infant mental health for Queensland.[534] The Children's Health Queensland HHS hosts QCPIMH. It works in partnership with other government departments, private agencies, tertiary institutions, NGOs and consumers and carers to develop a continuum of care in perinatal and infant mental health across Queensland. This continuum of care includes inpatient and ambulatory community-based services across all sectors of care.

The QCPIMH advised that:

> … one in five women will experience either anxiety and/or depression in that perinatal period. Thinking about dads within the family system, we also know that one in 10 dads will experience either anxiety or depression in that perinatal period. Those presentations are on a continuum, of course, so there are some milder presentations through to more moderate to severe presentations. There is also a cohort of women who experience puerperal psychosis, which is at more the severe end—that is two per 1,000 births.[535]

The QCPIMH explained the range of vulnerabilities that increase someone's risk during this time, for example:

- cultural factors
- homelessness
- domestic and family violence
- social and criminal justice issues
- access to employment
- mental health issues
- drug and alcohol misuse
- childhood sexual abuse or other abuse.[536]

The QCPIMH identified the following as essential for models of care in perinatal and infant mental health:

- keep parents and children as close to home as possible by providing home visits and localised services
- have a continuum of care that starts antenatally or even prior to that (eg a social worker could go with a nurse who is home visiting if required for a period of 2 years)
- provide early education and care experiences
- bring services and sectors together (eg housing may play an important role)
- support parents to engage and interact with their children and support communities to do the same (eg provision of playgroups, parks and libraries).[537]

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533 Submission, 144, p 22-23. NB: in-text referencing removed. Refer to original source for more information.

534 Public hearing transcript, Brisbane, 11 February 2022, p 19.

535 Public hearing transcript, Brisbane, 11 February 2022, pp 22-23.

536 Public hearing transcript, Brisbane, 11 February 2022, p 23.

537 Public hearing transcript, Brisbane, 11 February 2022, pp 29, 30.

The AMAQ stated that a reasonable period of time in hospital in the postnatal period would be beneficial to help parents transition into their roles. It would also provide time to identify further services that may be required.[538]

In regards to access to further services, the AMAQ added:

> If your consumers have low health literacy, if they come from your culturally and linguistically diverse communities and if they are First Nations, there will be a lot of barriers—cultural and understanding and health literacy barriers—for them to access the beginnings of care. Those initial referral services, particularly through midwifery and obstetrics and antenatal services, are critical. Whether we are doing that right or not you are going to have to ask experts, but it is certainly what we found to be most effective.[539]

QNMU noted the difference that nurses and midwives with mental healthcare experience and training can make in preventing postnatal depression. QNMU stated that more mental health training needs to be included in generalist training and '… more specialist training for those who deal with—I do not want to use the words 'worst of the worse', but more severe'.[540]

The Australian College of Nurse Practitioners (ACNP) considered an opportunity exists to integrate the work of child health nurses and midwives, especially for women who have complex and enduring mental health conditions, so that they are working closely together. ACNP stated:

> In your work as an MDT [multidisciplinary team], you are able to support women through from their antenatal journey into their postnatal journey. We upskill child health nurses and midwives in mental health and we try to reduce the infant's exposure to adverse childhood experiences. When parents are well mentally and are not using excessive substances, there is hopefully a reduction in domestic violence. We know that if we can get some of those things right, the projections for physical health by the time children become adults is way better by being able to re-examine funding and join services together, instead of working in our silos. We all have skills to offer, but we can do it together. I would love to have a child health nurse working in our perinatal mental health service. I would like to have infant clinicians working in our team, but we are funded for adults.[541]

The QMHC supported the view that perinatal and infant mental healthcare should be 'responsive and proactive support and care in the first 2000 days and is optimally provided through integrated, co-located, collaborative cross-agency services to families'.[542] The QMHC stated:

> 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.[543]

According to the QMHC, 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'.[544]

Committee comment

The committee recognises the service gap for those in the 'missing middle'. The committee also supports a person-centred mental healthcare approach that focuses on empowering people to choose services that are suitable for them. However, this relies on a) co-designing services with people with

538 Public hearing transcript, Brisbane, 17 February 2022, p 15, 16.

539 Public hearing transcript, Brisbane, 17 February 2022, pp 15-16.

540 Public hearing transcript, Brisbane, 10 March 2022, p 44.

541 Public hearing transcript, Brisbane, 10 March 2022, p 56.

542 Submission 151, p 4.

543 Submission 151, p 48.

544 Submission 151, p 49.

lived experience; b) mental health promotion strategies; and c) ensuring access to the full spectrum of services, including early intervention, are provided.

The committee supports the view of many stakeholders that providing a continuum of integrated mental health interventions, support and treatments requires collaboration across systems and services to ensure all the social determinants of mental health and wellbeing, including economic, housing, vocational, educational, social and recreational, are seamlessly supported. This continuum must also be responsive to the diverse needs of people who are at greater risk of mental ill-health.

As part of this process, the committee recommends that the Queensland Government investigate options for establishing person-centred community-based care/case management for people with mental health and/or AOD issues who are engaged with government agencies, such as Housing, Child Safety, Youth Justice and Corrections, and regardless of where they are being discharged from—HHS mental health services, custodial sentence and whether under parole or not—and consider the inclusion of adverse childhood events in its trauma-informed approach. These services may also be offered to people impacted by domestic and family violence, life threatening illnesses or injuries, the death of a child, sexual assault or any other traumatic event. The committee considers this case management model should follow the person, as opposed to being agency-focused.

Noting the importance of early intervention and prevention, it is also the committee's view that there is a need for a population-based mental health and wellbeing strategy that works across Queensland's human services portfolios. It is the committee's view this strategy should raise awareness of mental health and wellbeing in the community and consider strategies for how and where to seek help.

The committee also notes that under the Bilateral Schedule, the Queensland Government has agreed to be responsible for providing a range of early community support programs in key areas including for perinatal mental health, family support, CALD and refugee support, eating disorders, and Clubhouses.[545]

Recommendation 18 – Consider person-centred human services care/case management model

The committee recommends the Queensland Government investigates options to better share information across government agencies, such as Health, Housing, Child Safety, Youth Justice and Corrections, for the purpose of providing enhanced trauma-informed support and person-centred case management for people with mental health and/or alcohol and other drugs issues.

Recommendation 19 – Develop Mental Health and Wellbeing Strategy

The committee recommends the Queensland Government considers the development of a population-based Mental Health and Wellbeing Strategy that works across human services portfolios and is aimed at improving community mental health and wellbeing with consideration of implementation by Health and Wellbeing Queensland, in partnership with the Queensland Mental Health Commission.

Recommendation 20 – Expand community-based services and programs

The committee recommends the Queensland Government reviews existing community-based mental health services and programs and finds opportunities to expand services to support people recovering from and experiencing mental ill-health, such as the Stepping Stone Clubhouse model and other alternative models providing psychosocial interventions and supports.

[545] Queensland Health, tabled paper, public hearing, Brisbane, 29 April 2022, Bilateral Schedule of Mental Health and Suicide Prevention: Queensland, p 2.

Committee comment

As part of the co-design process in harnessing a person-centred approach to service delivery, the committee supports the view that people with lived experience be involved in all aspects of planning and delivering mental healthcare and alcohol and other drugs services in Queensland.

Recommendation 21 – Co-design mental health and alcohol and other drugs services with people with lived experience

The committee recommends the Queensland Government embeds people with lived experience in co-designing all aspects of planning, delivering and reviewing mental healthcare and alcohol and other drugs services in Queensland.

Committee comment

The committee supports the view that GPs and allied health professionals play a vital role in providing early intervention, prevention and other support services across the spectrum of need.

Recommendation 22 – Expand general practitioner mental health and alcohol and other drugs services

The committee recommends the Queensland Government liaises with the Australian Government to explore ways to expand and evolve general practitioner services into enhanced fit-for-purpose services for people experiencing mental ill-health and alcohol and other drugs issues.

Committee comment

The committee notes the evidence from the QNMU and ACNP regarding the positive impact that nurses and midwives with mental healthcare experience and training can make in preventing postnatal depression and providing support. See section 7.4.3 which includes a recommendation concerning scholarships to pursue mental health qualifications, including for nurses and midwives.

The committee supports additional assistance being provided to at-risk groups who may experience barriers to accessing services due to language, culture, and low health literacy.

Recommendation 23 – Improve mental healthcare support to people at greater risk

The committee recommends the Queensland Government establishes more nurse navigator roles to help families in high risk groups navigate perinatal and infant mental health services available to them.

6.3.4 Increasing mental health services for children and young people

6.3.4.1 Zero to 12 years olds

The QMHC considered that there is a mental health and wellbeing service gap for children from zero to 12 years old. The Commissioner advised:

> We have a service gap generally. We have infant and perinatal infant health in Queensland Health but again it is for the more severe, and this is where we do not have that service for zero to 12. I do think that the new Head to Health centres which the federal government will fund—and I think there are only a small number of them—are targeting the zero to 12, so they will start to address some of that.[546]

Other submitters also identified this age group as being subject to a significant gap in services. The QFCC stated that services should be available to all children, including those under the age of 12

[546] Public hearing transcript, Brisbane, 20 January 2022, p 34.

years.[547] The Brisbane South PHN stated that 'the current system focuses on specialist intervention rather than prevention and early intervention, and primarily on adults and adolescents rather than children' with evidence suggesting that '50 per cent of adult mental illness develops before the age of 14'.[548]

The Brisbane South PHN stated further that 'prioritisation of prevention, early intervention and mental health wellbeing responses focused on children and their families from the perinatal period is key', and that the response from local, state and commonwealth funding must be integrated and coordinated to improve health, social and economic outcomes for children and their families/carers.[549]

6.3.4.2 12 to 25 years olds

The Mater Young Adult Health Centre (MYAHC) was developed to respond to the specific needs of adolescents and young adults with a focus on transition from paediatric services and developmentally appropriate care.[550] MYAHC advised the committee that adolescents and young adults fall within the missing middle due to the lack of services for this age group:

> Adolescents and young adults certainly fall into that gap, particularly young people with moderate mental health concerns and internalising disorders, young people with co-existing alcohol and other drug concerns, disabilities and chronic diseases, young people leaving care, young people who are homeless or even young people without someone to advocate for them to help them manage the system and young people transitioning from child and youth to adult mental health services. This in itself is a systemic driven determinant of poor mental health outcomes for young people.[551]

Ms Grace Sholl, a QFCC Youth Advocate, advised of the overreliance on headspace, which provides services for 12 to 25 year olds experiencing mental ill-health:

> When we talk about youth mental health we always talk about headspace, but what happens when a headspace centre does not have the capacity to support another young person? What happens when there is not a headspace in the local area, which is the case for a lot of rural areas? If that young person cannot afford private support, which is the case for many young people like myself who are university students living on Centrelink, and if they cannot access headspace they often reach the end of the line.[552]

6.3.4.3 Transitions between youth mental health services and adult services

Orygen submitted that the transition from child and youth mental health services, where services typically cease at 18 years old, to adult mental health services can be a point of high risk and disruption for adolescents and their families.[553]

According to Orygen, evidence from Australia, Canada, the United Kingdom, and the United States has consistently confirmed that it is very difficult to provide coordinated and integrated youth mental health services during this period of transition.[554]

MYAHC explained the fragmentation between the youth and adult mental health services:

> The main issue that we see is the fragmentation of care. We see fragmentation between child and adult services. We know that a lot of young people drop out of services in that transition. We see a gap between

547 Submission 128, p 4

548 Submission 87, p 7.

549 Submission 87, p 7.

550 Submission 129, p 3.

551 Public hearing transcript, Brisbane, 11 February 2022, p 10.

552 Published in camera hearing transcript, Brisbane, 11 February 2022, p 2.

553 Submission 73, pp 9-10.

554 Submission 73, pp 9-10.

> medical services and mental health services. In my world, there is an 80-20 rule whereby with our medical services probably 20 per cent of young people make up 80 per cent of the work. That is due to underlying mental health problems. The final fragmentation is between health and the wider community, especially education and other community services. This leads to multiple fragmentation and multiple providers.[555]

Orygen advised that the transition to adult mental health services is '95 per cent of the time' a failure. For the small number of children who can access child and youth mental health services, they fail to make the transition to the adult system because it is:

> … designed for the post-asylum cohort, people with chronic severe mental illnesses, most of whom, in the public mental health system, have an average age of about 40. So you have your 18-, 19- or 20-year-olds, even if they do happen to get in, surrounded by people maybe two decades older than themselves. It is a very frightening experience for a young adult to be planted in the middle of an acute admission ward surrounded by 45-year-olds with chronic mental illnesses, so you have to have a separate stream of care which extends up to at least the mid-20s to cover that transition point.[556]

The Royal Commission into Victoria's Mental Health System acknowledged that conflicting age boundaries added disruption in treatment, required young people to retell their experience and access services that are not always aligned with their needs. The Royal Commission recommended that state services adopt an age-based system for infant, child and youth mental health and wellbeing including age streams of zero to 11 years and 12 to 25 years. The age boundaries and transitions were recommended to be applied flexibly in partnership with young people and their families, carers and supporters.[557]

6.3.4.4 School-based mental health

The committee heard from several stakeholders on the importance of school-based mental health curriculum and supports.[558] headspace considered that schools are a key platform for providing mental health services that engage children, young people, and families along the continuum of intervention for health and wellbeing, stating:

> Not only are schools well-accustomed to supporting students' learning and developmental needs, they also help students to develop resilience, social and emotional health, and confidence in seeking services and treatment. For these reasons, schools have long been regarded as suitable environments for implementing suicide prevention initiatives for vulnerable young people. Over recent decades, schools have also become recognised as important sites for postvention, which involves responding to the mental and physical health and wellbeing of students and staff, both immediately following a suicide and in the longer term.[559]

A QFCC Youth Advocate, Ms Alyssa Ikefuji, described the barriers to identifying mental ill-health and the need for greater mental health education in schools:

> I do not know if this is your experience but asking for help can be really hard, especially if you do not know what is wrong with you. The conclusion that you come to is that it is you who is the problem. I remember writing about coming home from school and just lying on the hardwood floor for hours at a time, unable to summon the energy to take a shower or even move as just being lazy. Once you get into that mindset, that what you are experiencing is a 'you' problem rather than some sort of acceptable reason, you are the one who dismisses the thought of getting help because, 'Oh no, I don't have a mental illness', but you don't know enough about mental illness in general to actually even make that call. One of the potential solutions to this problem is for mental health education to be added to schools and I

555 Public hearing transcript, Brisbane, 11 February 2022, p 10.

556 Public hearing transcript, Brisbane, 17 February 2022, p 18.

557 Orygen, submission 73, pp 9-10.

558 See, for example, submissions 66, 73 and 128.

559 Submission 66, p 6.

> would recommend it be added to one of the core curriculum aspects of education, and also increased counselling services in schools.[560]

Another Youth Advocate, Ms Holly Hudson, recommended the following to reduce the barriers to young people accessing mental health care:

> … making sure that access to mental health services is practical and convenient rather than being an inconvenience for you to have to search out and go out of your way to get access to basic human health care. This means having counsellors, psychologists and GPs in schools, universities and prominent workplaces that young people are a part of. Further to this, there should not be an extensive waiting period because there are so many people trying to access these services. Online services work for some people but they do not work for everyone.[561]

As noted above, one of the challenges being experienced is that demand for mental health services is greater than the current capacity. Queensland Catholic Education Commission added:

> As a result, school counsellors and the other professional staff in schools are dealing with an increased number of cases of significant and increasing complexity. Our schools also report difficulty in attracting and retaining wellbeing staff, most especially for our rural and remote schools.[562]

Independent Schools Queensland (ISQ) also reported their schools were experiencing an 'increasing prevalence of students experiencing social and emotional difficulties, including students waiting for appointments with mental health clinicians'.[563] ISQ also commented on waiting times and the increase in demand for services:

> Some schools report long waitlists to access external psychologists, psychiatrists and paediatricians, with six to 12 months wait in some areas commonly reported. As an indication of the increasing prevalence of students requiring social and emotional support, from 2016 to 2021 the number of applications to ISQ from our member schools for state government funding for students who have been diagnosed with a psychiatric disorder and require significant educational adjustments increased by 138 per cent.[564]

ISQ expressed concern about the wellbeing of their staff as a result:

> Consistent with schools in other sectors, our sector is also concerned about the wellbeing of staff, a situation that is further exacerbated by COVID-19. We recognise that staff wellbeing is important for student wellbeing and are doing some work and research in this space that we are happy to provide the committee. Again, school staff report being inadequately trained and supported to take on this additional responsibility with, at times, inconsistent responses from clinical service providers. Accessing clinical support for students following self-harm appears to be a particular concern for a number of our staff. Across our sector, our schools employ a range of different types of staff to support student wellbeing including psychologists, counsellors and social youth workers, for example. In response to the increasing support needs, many independent schools are reviewing the type of support services they provide and how they can more effectively provide those services.[565]

The committee acknowledges that help-seeking in the school environment may not be suitable for all school-aged children and young people.[566]

The Department of Education stated that its strategy for all state schools is 'Every student succeeding', stating further:

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560 Published in camera hearing transcript, Brisbane, 11 February 2022, p 4.

561 Published in camera hearing transcript, Brisbane, 11 February 2022, p 5.

562 Public hearing transcript, Brisbane, 11 February 2022, p 1.

563 Public hearing transcript, Brisbane, 11 February 2022, p 2.

564 Public hearing transcript, Brisbane, 11 February 2022, p 2.

565 Public hearing transcript, Brisbane, 11 February 2022, p 2.

566 Public hearing transcript, Brisbane, 11 February 2022, p 2.

> This means we focus on the needs of students to ensure the success of every child, both in terms of their learning and in terms of their mental health and wellbeing. Guided by our Student Learning and Wellbeing Framework, schools take a whole-school approach to supporting all students' mental health and wellbeing across the continuum of care. This includes whole-school approaches to providing universal prevention and promotion through to, at the school, providing support for students with mild to moderate mental health concerns and assisting students and their families to access specialised intensive support in the community when it is required. Developing and sustaining positive relationships, having mental health literacy and being able to ask for help when it is needed are the key components of good mental health. To support children and young people to develop these personal and social capabilities, we deliver social and emotional learning through the curriculum.[567]

The Department of Education stated it had strengthened its approach to supporting the mental health and wellbeing needs of students, advising:

> … the department is implementing a $100 million student wellbeing package. The package will see state primary and secondary school students across the entire state with increased access to a psychologist or other similar wellbeing professional. Over three years, we will be employing up to 464 full-time-equivalent wellbeing professionals. In term 1 of this year we already have 62 new wellbeing professionals in our schools, and this includes 49 psychologists amongst that 62.
>
> …
>
> We are also conducting a pilot where we are placing GPs in 50 state secondary schools. This will allow secondary students with access to a GP on school grounds one day a week. This will overcome some of the barriers young people often experience in accessing health care within the community. We know that providing access to GPs will also play a pivotal role in the early intervention for mental health concerns. Our colleagues in Queensland Health attest that access to GPs and generalist health services as part of a stepped model of mental health care is critical in preventing conditions from worsening.[568]

6.3.4.5 Early psychosis services

The committee heard from Professor James Scott in his capacity as a member of the Child and Youth Research Group, QIMR Berghofer Medical Research Institute, who advised of the need for excellent services for young people with serious mental disorders.[569]

The Early Psychosis Service provides frequent community-based care to young people between 18 and 24 years old. The Early Psychosis Service supports individuals in the Prince Charles Hospital and Royal Brisbane and Woman's Hospital catchment area who are having a first experience of psychosis or where there is a high risk that they will develop psychosis.[570]

Professor Scott provided the following example of the role early psychosis services can play in young people's lives:

> On a Sunday afternoon in September, I got a phone call from a doctor in the emergency department. A young person, year 12, about to sit their ATAR exams had been sitting there with their parents for about five hours. He had not gone to school for a couple of weeks. He had been experiencing paranoid delusions for a few months and had really been unable to concentrate and focus on his schoolwork. He was heading towards, after 12 successful years at school, missing out on a final ATAR score and missing out on going to university, looking at lifelong disability as a result of a serious mental illness. The doctor on called me and said, 'He's psychotic. He's suicidal. We need you to meet him but the parents do not want him in a general adult hospital with all those older people with chronic schizophrenia.' I said, 'Look, send him

567 Public hearing transcript, Brisbane, 11 February 2022, p 1.

568 Public hearing transcript, Brisbane, 11 February 2022, p 2.

569 Public hearing transcript, Brisbane, 11 February 2022, p 13. NB: Professor Scott is also the Director of the Early Psychosis Service.

570 Metro North Health, The Prince Charles Hospital, 'Early Psychosis Service (mental health)', https://metronorth.health.qld.gov.au/tpch/healthcare-services/early-psychosis-service-mental-health.

> home. My early psychosis service will see him tomorrow.' We saw him several times a week for the next few weeks and got him the right medication. We liaised with the school so he was exempted from the ATAR exams. He managed to go to Schoolies Week that year. He managed to get an ATAR exam. He is now back doing his activities. He now has a part-time job. He is starting university next week and going to O Week. This is the difference that mental health services can make to young people if they are properly provided.[571]

Professor Scott explained that this individual was 'lucky to live in a catchment area for a service that has a specialist early psychosis service', and that had he lived elsewhere in Queensland:

> he would have been placed in the adult mental health ward with 30-, 40- or 50-year-old people with chronic mental disorders. He would have probably gotten placement medications that would cause weight gain and other problems. He would have probably never finished his schooling because they would not have liaised with the school. He would now be sitting at home wondering what he is going to do with the rest of his life.[572]

Professor Scott explained that there is an overinvestment in mild to moderate disorders, and there is a need for more specialist youth mental health services so people can step up their care and get the care they need.[573]

6.3.4.6 Eating disorders

The Queensland Mental Health Commissioner advised that there has been a disproportionate increase in eating disorders for young people.[574] The QNMU advocated for more school health nurses, as a response to 'the absolute explosion of eating disorders being experienced by both young men and women in schools'.[575]

Eating Disorders Queensland told the committee:

> One of our big concerns at the moment is that a lot of the public health messaging is very focused on obesity. There is a lot of evidence that says that that is directly leading to disordered eating and eating disorders. I think we can move away from that obesity messaging. One of the key recommendations of the federal obesity select committee last year was not using the term 'obesity' anymore because it is so stigmatising and shaming. It is moving away from that messaging or at the very least including eating disorder expert consultation in the development of public health campaigns in the prevention space would be important.[576]

In response to questions about social media and body image, Eating Disorders Queensland added:

> There is a lot of room for preventive programs that are based on positive messaging. For us, it is about building connection and community that is not focused on body image or weight but is just about supporting each other and essentially replacing all of that time spent on social media and hearing those messages with time spent connecting with others and building up your self-esteem.[577]

With respect to eating disorders, Eating Disorders Queensland reported that stigmatising views about eating disorders are common within the community, and added:

> There is a strong link between the low level of help-seeking among people with eating disorders and link to stigma. Less than one in four people (23.2 per cent) with eating disorders seek professional help. Stigma and shame are the most frequently identified barriers for accessing treatment. Other factors

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571 Public hearing transcript, Brisbane, 11 February 2022, p 13.

572 Public hearing transcript, Brisbane, 11 February 2022, pp 12-13.

573 Public hearing transcript, Brisbane, 11 February 2022, p 13.

574 Public briefing transcript, Brisbane, 20 January 2022, p 31.

575 Public hearing transcript, Brisbane, 10 March 2022, p 49.

576 Public hearing transcript, Brisbane, 11 March 2022, p 26.

577 Public hearing transcript, Brisbane, 11 March 2022, p 26.

include denial of and failure to perceive the severity of the illness, practical barriers such as cost of treatment, low motivation to change, negative attitudes towards seeking help, lack of encouragement from others to seek help, and lack of knowledge about help resources.[578]

The RANZCP advised the committee that there are only 5 specified eating disorder beds in the state.[579]

Committee comment

The committees notes the increased vulnerability of children and young people to mental ill-health, and the critical nature of the early years of life for lifelong mental health and wellbeing. The committee has heard evidence of a concerning increase in the prevalence of mental ill-health for children and young people, particularly among school-age children.

The committee acknowledges the need for greater integration and availability of mental health services for children and young people. The committee considers that the Bilateral Schedule signed by the Queensland and Australian Governments will go a long way toward improving services for children and young people.

The committee notes the investment in child mental health and social and emotional wellbeing agreed to by the Australian and Queensland Governments includes:

- co-funding the establishment of two Head to Health Kids Hubs in Queensland with agreed areas of policy, funding and service delivery responsibility
- working collaboratively to continue to improve access to multidisciplinary team care for infants and children up to the age of 12
- working together to flexibly implement a model that aligns with the national Head to Health Kids Service Model and integrates with existing services.[580]

The committees also acknowledges the commitment to enhance and integrate youth mental health services:

- the Australian Government has agreed to:
  - fully-fund the establishment and operation of two new headspace sites in Queensland
  - fund the enhancement of new and existing headspace services in Queensland.
- the Queensland Government has agreed to provide funding directly to HHSs to support employment of specialist clinicians to support clinical in-reach and dedicated consultation-liaison to new and existing headspace sites, with the aim of enhancing integration and consistent with the headspace model.[581]

With respect to service integration, the Australian and Queensland Governments have agreed to work together to:

- enhance current and planned headspace services to increase access to multidisciplinary youth mental health services in Queensland, with a focus on ensuring young people can access an appropriate level of support, wait times are minimised, and transition between headspace and Queensland's mental health and alcohol and other drug services is streamlined

578 Submission 96, p 2.

579 Public hearing transcript, Brisbane, 12 April 2022, p 57.

580 Queensland Health, tabled paper, public hearing, Brisbane, 29 April 2022, p 7.

581 Queensland Health, tabled paper, public hearing, Brisbane, 29 April 2022, pp 7-8.

- identify an approach to improving access to multidisciplinary treatment and care for adolescents and young people aged 12 to 25 years, while supporting integration with existing services in Queensland.[582]

Recommendation 24 – Expand headspace services in Queensland

The committee notes the work being undertaken as a result of the Bilateral Schedule and recommends the Queensland Government continues to expand headspace services in Queensland as needed.

Committee comment

The committee acknowledges that services better serve children, young people and their families when they are integrated, co-located, flexible and are not disrupted by age boundaries.

Recommendation 25 – Improve the delivery of mental health and alcohol and other drugs services for young people

The committee recommends the Queensland Government reviews:

a) the delivery of its youth mental health services and considers how it could better integrate and co-locate services to provide more holistic care to young people with consideration given to models such as the Mater Youth Health Service.

b) the age boundary between Child and Youth Mental Health Services and Adult Mental Health Services to help support the seamless transition between the two stages of healthcare and provide flexibility in transition planning based on an individual's needs.

Committee comment

The committee supports the view that schools provide a place for young people to access mental healthcare services while also acknowledging the challenges for schools and staff that this creates. The committee also notes the Queensland Government's funding of $100 million for student wellbeing packages and its initiative to put GPs in 50 state secondary schools. While these strategies are encouraging, the committee is of the view that more services are needed for young people to support them and decrease waiting times for services and makes the following recommendations in this regard.

The committee notes recommendation 49 in section 7.4.3, regarding leveraging counsellors in settings including schools.

Recommendation 26 – Increase mental health support services in schools

The committee recommends the Queensland Government increases the availability of general practitioner, psychologist, and nursing services available in Queensland schools, including encouraging the uptake of these services in non-government schools.

Committee comment

The committee understands there is a need to increase early intervention psychosis services to provide support and care to young people in the early stages of an episode of serious mental ill-health.

[582] Queensland Health, tabled paper, public hearing, Brisbane, 29 April 2022, p 8.

Recommendation 27 – Expand availablity of Early Psychosis Service to support young people experiencing serious mental ill-health

The committee recommends the Queensland Government expands the Early Psychosis Service currently operating out of The Prince Charles Hospital into each Hospital and Health Service.

6.4 Crisis and emergency care

In 2020, over 59,000 people phoned Triple Zero (000) because of a mental health crisis.[583] Queensland Health advised:

> … this was a 15 per cent increase from 2019. The QAS has seen an upward trend for calls for mental health emergencies to Triple Zero (000) of between 15 per cent and 20 per cent per annum for the past five years.[584]

About 1 in 8 jobs for the QAS are responding to people experiencing a mental health crisis. Queensland Health explained that calls to the QAS relating to mental health crises cover a broad range of situations including 'high risk scenarios; an exacerbation of an existing mental health condition; a suicide crisis; significant life events; domestic violence; drug and alcohol use/issues; and aberrant type behaviours'.[585]

According to Queensland Health, mental health crisis situations presenting to the QAS are often a complex interplay of physical, social and psychological factors. Over half of the calls to Triple Zero for people in mental health crisis involve a suicide crisis, including ideation, intent, suicide attempts or death by suicide, with the remaining experiencing distress, risk taking, emotional dysregulation or unmanageable or abnormal behaviours.[586]

A person experiencing a mental health crisis may experience suicidal behaviours including suicidal thoughts or suicide attempt. A person experiencing a mental health crisis may or may not have a diagnosable mental illness or substance use disorder.[587]

HHSs and NGOs provide a range of supports and services for people experiencing mental health crises.[588] The services provided by HHSs and NGOs include those offered by 'emergency departments, acute, community and inpatient care teams'. Queensland Health advises that these teams 'assess, formulate, plan, and coordinate the delivery of crisis care in partnership with NGOs and primary care providers to support referral and follow-up care'.[589]

Queensland Health acknowledged that the impact of increasing demand and resourcing constraints has seen the mental health system 'reorient over time to focus on crisis responses'. Queensland Health further stated that 'this includes limiting a range of supports that have demonstrated the ability to prevent emerging MH crisis, reduce the likelihood of relapse and potentially reduce loss of life'. This 'lack of outreach capacity in turn results in more people in crisis presenting to EDs or defaulting to non-MH interventions such as those provided by ambulance or police'.[590]

583 Not all calls to QAS result in a job for the QAS.

584 Queensland Health, briefing paper, 1 February 2022, p 12.

585 Queensland Health, briefing paper, 1 February 2022, p 12.

586 Queensland Health, briefing paper, 1 February 2022, p 12.

587 Queensland Health, briefing paper, 1 February 2022, p 10.

588 Queensland Health, briefing paper, 1 February 2022, p 10.

589 Queensland Health, briefing paper, 1 February 2022, p 10.

590 Submission 150, p 81.

6.4.1 Emergency departments

Emergency departments are one component of the continuum of care for mental health crisis services.[591] Mental health presentations to EDs have increased by 20% with referrals to specialised services also growing by 20%. The impact of COVID-19 on mental health has also increased demand, particularly from young people.[592]

Stakeholders recognised that EDs have, as QMHC noted, 'by default and necessity … become the entry point to mental health treatment, care and support'.[593] The QMHC stated that 'service gaps at the ambulatory care and community-based levels are a driver of increased presentations to the emergency department' with the high demand on EDs meaning 'people may experience lengthy delays in assessment and treatment, particularly if inpatient care is required'.[594]

Several stakeholders stated that EDs and hospitals are not the best place for people who are experiencing a mental health crisis, including those at risk of suicide.[595] The QMHC stated that EDs 'can be inappropriate, unsuitable, or harmful environments for people experiencing significant distress'.[596]

Queensland Health advised that evidence shows that reliance on EDs and police 'is less effective and more expensive than community-based MH crisis intervention models of care'. Queensland Health continued:

> People in crisis and their families often describe frustration trying to access and navigate the MH care system when in crisis, and present to the ED in crisis because they believe they do not have access to better options of support. People who present to EDs with a MH issue often report the ED as unwelcoming, overcrowded and over-stimulating, wait longer to be seen than other patients, have longer stays in the ED and are more likely to leave before their treatment is completed. The high stimulus environment can lead to escalation of distress and use of restrictive practices. Individuals in Queensland with lived experience of MH crisis have themselves strongly voiced the need for more sophisticated responses.

Queensland Health also discussed the *National Mental Health Service Planning Framework* (NMHSPF):

> It is recognised that when provided with the right support and within the right setting, many people can move through a MH crisis without the need for ED or inpatient care. Some people will require inpatient care and access to inpatient MH beds in Queensland remains a significant concern with a large gap between NMHSPF recommendations and existing bed stock.
>
> While the NMHSPF is an important tool for identifying, planning and resourcing a wide range of state-funded specialised MH services, it has been recognised that the framework does not adequately address the delivery of care to people experiencing MH and suicidal crisis, many of whom do not have an underlying severe mental illness and does not, at this point, encompass a range of innovations that have been emerging locally and internationally to improve crisis care.[597]

In relation to suicide and EDs, Suicide Prevention Australia stated:

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591 Queensland Health, submission 150, p 89.

592 Submission 150, p 81.

593 Queensland Mental Health Commission, briefing paper, 20 January 2022, p 2.

594 Queensland Mental Health Commission, briefing paper, 20 January 2022, p 19. NB: in-text referencing removed. Refer to original source for more information.

595 See, for example, Suicide Prevention Australia, submission 25; Queensland Health, submission 150.

596 Queensland Mental Health Commission, briefing paper, 20 January 2022, p 19. NB: in-text referencing removed. Refer to original source for more information.

597 Submission 150, pp 81-82. NB: in-text referencing removed. Refer to original source for more information.

> All deaths by suicide are preventable. It is critical to build prevention capability within key community touchpoints for entering the Queensland health service system to ensure vulnerable people are identified and connected with appropriate support. A person-centred approach that recognises EDs are not best suited for people at risk of suicide is required, and alternatives to EDs (such as Safe Spaces and connecting people with community-based supports) should be available.[598]

Queensland Health also recognises the importance of creating 'culturally welcoming' emergency department service environments to support Aboriginal and Torres Strait Islander peoples experiencing crisis when presenting to an HHS.[599]

6.4.2 Alternatives to emergency departments

Service gaps at the ambulatory (outpatient) care and community-based levels lead to more people with mental ill-health presenting at EDs.[600] As noted above, EDs are not considered an ideal place for a person experiencing a mental health crisis: they can be noisy and people often have to wait a long time for a bed. In some instances, the person does not need the services available at a hospital but does not have anywhere else to seek assistance (or know how to find that assistance).[601]

Stakeholders proposed several alternatives to EDs in relation to managing mental health crises, including:

- developing 'warm entry points'[602]
- ensuring adequate and appropriate resourcing at the non-acute/middle level of healthcare[603]
- active follow up after ED presentations and administrations[604]
- using 'safe spaces'[605]
- expanding co-responder models[606]
- Head to Health centres.[607]

6.4.2.1 Warm entry points and adequate resourcing for early intervention

The QAMH sought consideration of developing 'warm entry points and locally-based community services' to meet wellbeing needs, so 'people can seek help early in distress without first having to go through a medical pathway or have a diagnosis'. The QAMH recognised this would require additional funding and developing a workforce strategy:

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598 Submission 25, p 9.

599 Submission 150, p 10.

600 Queensland Mental Health Commission, briefing paper, 20 January 2022, p 19. NB: in-text referencing removed. Refer to original source for more information.

601 Queensland Mental Health Commission, submission 151, pp 99-100.

602 QAMH, public hearing transcript, Brisbane, 10 March 2022, p 23.

603 Queensland Mental Health Commission, briefing paper, 20 January 2022, p 19. NB: in-text referencing removed. Refer to original source for more information.

604 Queensland Health, submission 150.

605 See, for example, Suicide Prevention Australia, submission 25; Queensland Mental Health Commission, public briefing transcript, Brisbane, 20 January 2022; Mia Pattison, submission 159.

606 See, for example, Queensland Nurses and Midwives' Union, submission 112.

607 See, for example, Queensland Mental Health Commissioner, public briefing transcript, Brisbane, 20 January 2022, p 30; QAMH, submission 119, p 15.

> It would require investment, though, in a workforce strategy beyond the clinical workforce to develop career pathways into the community mental health and wellbeing sector. We would need to invest in evaluation but allow enough time and resources for these sorts of initiatives to really be shown to be alternatives to what we already have.[608]

The Queensland Mental Health Commissioner also commented on the importance of early intervention to reduce the number of people presenting to EDs:

> If we shifted the system towards the middle ground where more people could get in early and stop the trajectory of people getting in late and ending up in EDs and in the public mental health system then we would have shifted the system in a different direction. That is what consumers, families and the broader community are calling for.[609]

The QMHC also stated that the current demand for crisis care and support could be reduced by adequate and appropriate resourcing at the non-acute/middle level of healthcare. The QMHC added:

> Adequate and commensurate resourcing at this level would enable support to people whose needs cannot be solely supported through primary healthcare but who also miss out on the more clinical, community and hospital-based mental healthcare and support due to high demand.
>
> 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.[610]

6.4.2.2 Co-responder model

Queensland Health's Mental Health Co-Responder model (MH CORE) is a component of the continuum of care for mental health crisis services and 'puts mental health clinicians on the road with Queensland Ambulance Service and Queensland Police Service to respond to incidents in the community where mental health concerns could be a factor'.[611] Emergency services and mental health nurses respond to mental health emergencies to provide on-the-spot and in-home assessment and treatment plans, which often results in the patient being diverted from presenting at an ED.[612]

Queensland Health recognises that the complexities in assessing and caring for people who are experiencing a mental health crisis prove a challenge for emergency medical dispatchers (EMDs), paramedics on scene and into the ED. To support EMDs and paramedics, the Mental Health Liaison Service (MHLS) in the Operations Centre is available state-wide 24 hours a day.[613]

In regards to the success of MHLS, Queensland Health advised that the evaluation of co-responder initiatives is progressing. During October 2021, for example, 'following active intervention by the MHLS clinicians, an ambulance attendance was avoided (and possible subsequent transport to hospital for further interventions) for 306 people who called Triple Zero (000) with a MH emergency'.[614]

The QAS MH Response Program, called the QAS MH CORE, 'pairs a senior Queensland Health MH Clinician working alongside a QAS paramedic within specific areas', including the Gold Coast, West

608 QAMH, public hearing transcript, Brisbane, 10 March 2022, p 23.

609 Queensland Mental Health Commissioner, Brisbane, public briefing, 20 January 2022, p 28.

610 Queensland Mental Health Commission, briefing paper, 20 January 2022, p 19. NB: in-text referencing removed. Refer to original source for more information.

611 Metro South health, 'The frontline of defence in mental health crisis care', https://metrosouth.health.qld.gov.au/news/the-frontline-of-defence-in-mental-health-crisis-care.

612 Queensland Nurses and Midwives' Union, submission 112, p 13.

613 Submission 150, p 127.

614 Submission 150, p 86.

Moreton, Metro South, Metro North, Sunshine Coast, Cairns and Townsville.[615] Queensland Health explained more about the program:

> The collaboration between the QAS and participating HHSs has seen a pivot in how MH services are delivered from hospital-based emergency response, to seeing people in their own homes.
>
> The service aims to be a first and health response to people who are experiencing a MH crisis in the community, consistent with the views and wishes of consumers and carers in the MH sector. The QAS MH CORE provides timely and thorough physical health, mental state, and risk assessment with management/treatment plans, for people in their own home, using their own resources and supports.[616]

Importantly, QAS MH co-responders can facilitate access to appropriate follow up and referrals. While Queensland Health advised that further investigation of the QAS MH CORE (in conjunction with the QPS MH response programs) is underway, 'between 60 and 70 per cent of the time the consumer avoids hospital presentation by identifying and implementing appropriate treatment pathways for people experiencing a MH crisis'.[617]

Queensland Health recognises the role that co-responder models play in mental health care and advised:

> The success of the QAS MH CORE in providing high quality outcomes for people experiencing a MH crisis, as well as for creating efficiencies throughout the health system as a whole, has been acknowledged through with the expansion of the program from three pilot sites in 2019 to recurrent funding for 17 additional sites throughout the state by 2024.
>
> As the program develops and expands throughout the state there is potential for further development and enhancement of the service through: the development of the program in regional areas; the development of shared definitions and operating procedures; further collaboration with stakeholders; improved dispatch processes and streamlining/refinement of the reporting requirements of the MH clinicians to increase the capacity of the program service delivery.
>
> The QAS MH CORE demonstrates the importance of outreaching MH crisis responses to people in their own environment and empowering them to utilise their own resources to manage the crisis. There is considerable recognition of the importance of a timely and appropriate response to people experiencing a MH crisis, and how if this is done effectively, can support a person out of crisis and significantly contribute to their recovery journey.[618]

In regards to the interaction with the QPS, Queensland Health advised:

> The MH Liaison Service - Police Communications Centre (MHLS-PCC) embedded MH consultation-liaison role since 2015, it has been positively evaluated, won a QPS award for excellence (2016, Customer Focus) and was identified in the 2020 National Productivity Commission Report as a case study demonstrating innovative practice that should be considered by other States and Territories. The MHLS-PCC service co-locates experienced NIH clinicians from the QFMHS within the Brisbane Police Communication Centre...
>
> Information sharing is supported through a Memorandum of Understanding (MOU) NIH Collaboration (2017) that ensures best practice in balancing confidentiality and service collaboration. It currently operates until 11pm, 7 days a week.
>
> The Police MH co-responder model is a Queensland multidisciplinary secondary response to MH situations, in which health services and police officers work together as a response unit in selected HHSs.[619]

615 Submission 150, p 128.

616 Submission 150, pp 128-129.

617 Submission 150, p 86.

618 Submission 150, p 129.

619 Submission 150, p 86.

While the Public Advocate acknowledged that co-responder models have been successful and that the program gives the QAS the ability 'to provide a health-based response as the first response in the community and to provide mental health interventions in homes', they expressed the view that 'the ability to support patients is often limited given the capacity of community mental health teams and the limited resources available to provide ongoing support'.[620]

The QMHC stated that co-responder programs help to relieve the pressure on ambulance services, decrease presentation to EDs and assist in de-escalation.[621]

Roses in the Ocean supported co-responder programs and added that the ideal would be to have a person with lived experience of the particular crisis accompany QPS or QAS.[622]

DV Connect commended the multidisciplinary approach being taken in regards to responding to crisis in homes and communities, including the co-responder model:

> I think it is about how first and foremost we understand what a common risk and safety assessment would look like depending on where she—and I will use that language—might access support. It is not only that but also having the confidence to undertake that assessment and to know where those referrals are beyond that—to have a multidisciplinary approach to how we deliver comprehensive patient care, particularly in touchpoints where we know there is greater risk. In maternity care in particular, we find that domestic and family violence, shockingly, can actually first present when she is pregnant. DVConnect, for instance, has done some significant work with the Nurses and Midwives' Union and conducted comprehensive training on how to recognise, respond, refer and report, because we see that is a really critical area.
>
> Conversely, it is how we think about a multidisciplinary approach within domestic and family violence specialist response and how that is informed by mental health practitioners and experts. I think we have seen some exceptional examples of how this can be done in the co-responder model with Queensland police and QAS for mental health. We are seeing the same kinds of really incredible outcomes and responses at that point of crisis by having co-responders for domestic and family violence specialists who are attending. I think that is incredibly supportive for the police to do their job but also to make sure there is that wraparound support. Therefore, we would also think there is a priority to have greater inclusion of mental health and drug and alcohol specialists within a high-risk team environment and to have that more broadly invested across the state, just to begin with.[623]

The QNMU recommended expanding co-responder programs to strengthen and expand existing community-based mental health services.[624]

In regards to the co-responder program, Queensland Health acknowledged that 'more needs to be done', stating:

> Queensland Health is working to identify solutions and a longer-term investment framework to support ongoing service improvement, resolve existing gaps, and meet growth in demand. Queensland Health is working with partners across the healthcare network to build robust and responsive services which meet the needs of Queenslanders. The QAS Mental Health Co-Responder project is an example of this collaboration. A mental health clinician is paired with a QAS paramedic to respond to people in a mental health crisis. More than 65 per cent of the people seen by the QAS mental health co-responder teams are kept away from emergency departments and the hospital system. To do this, we use key planning

620 Submission 143, p 5.

621 Public hearing transcript, Brisbane, 20 January 2022, p 33.

622 Public hearing transcript, Brisbane, 18 February 2022, p 14.

623 Public hearing transcript, Brisbane, 11 March 2022, p 17.

624 Submission 112, p 5.

> frameworks and tools and work in strong partnership with HHSs, people with a lived experience, PHNs and key peak representative organisations.[625]

6.4.2.3 The use of 'safe spaces'

Several stakeholders called for the introduction of 'safe spaces' as an alternative to relying on EDs for treating mental health crises.[626]

The QMHC explained the operation of 'safe spaces' in more detail:

> If I am right, initially the Safe Spaces model was called Safe Space Cafe. Primarily it came from the UK where, for example, if you were in distress—some people do turn up to ED—rather than going to ED you could go to a Safe Space cafe, have a cup of coffee with a clinician, a peer worker, and work through some of the issues that are happening for you. These are those more informal options for people who might be in situational crisis but who do not need an ED or a hospital admission. We are rolling out about eight of those—and John might be able to confirm some of that—that the state government has funded. We are looking to expand those options across the state. I know the primary health care networks are also funding some of those. I see those as opportunities where people can go and get support. I certainly visited the one in Victoria to look at how it operates. It is really a drop-in place—picking up the member's point—where people can come. Because of the location in Victoria, it really attracts a lot of homeless people who will end up in ED but who actually come to the Safe Space cafe. I think we are talking about the same thing when you mention that cafe. It is really about sitting down and having a coffee.
>
> In some of the ones in the UK, it is like a cafe really. You come in, sit down and have a coffee. In fact, one of them I saw had a couple of consulting rooms at the back where you could have a quiet conversation on the lounge with somebody. There are slightly different models. Some are totally peer-run. You come in and you talk to peers. Others have a combination of peer and clinicians. We have also seen some that are much more allied health, clinical-run. The model depends on what you have got in the rest of your architecture within your catchment area.[627]

Submitter, Ms Pattison supported 'safe spaces' that employ peer support workers as an alternative to a person having to present at an ED for help. She cited a study that showed in the first 3 months of operation of a mental health peer support service that provided hospital avoidance and early discharge support to consumers of adult mental health services, 300 bed days were saved, saving a net amount of $93,150.[628]

See section 6.4.3.1 for more information and recommendations about 'safe spaces' as an alternative to ED and an early prevention strategy.

6.4.2.4 Head to Health centres

The Commonwealth Government's Head to Health initiative is intended to address the missing middle along the mental health care continuum.[629]

A Head to Health adult mental health centre has been established in each state and territory to provide a safe space for people in crisis, and for their family and friends, and help for those needing to find

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625 Public hearing transcript, Brisbane, 20 January 2022, pp 2-3.

626 See, for example, Suicide Prevention Australia, submission 25; Queensland Mental Health Commission, public briefing transcript, Brisbane, 20 January 2022; Mia Pattison, submission 159.

627 Queensland Mental Health Commission, public briefing transcript, Brisbane, 20 January 2022, p 37.

628 Submission 159, p 6; S Lawn, A Smith and K Hunter, 'Mental health peer support for hospital avoidance and early discharge: An Australian example of consumer driven and operated service', *Journal of Mental Health*, 2008, vol 17(5).

629 Queensland Mental Health Commissioner, public briefing transcript, Brisbane, 17 February 2022, p 2. See also https://www.headtohealth.gov.au/.

mental health services.[630] Further centres will be established in coming years, including a possible 5 centres and 7 satellite centres over a 5 -year period in Queensland.[631]

The centres are designed to provide a welcoming entry point to engagement, assessment and treatment for people who are distressed or in crisis. They are staffed by multidisciplinary teams and will not require a referral or an appointment or the payment of a fee.[632]

The Commissioner holds the view that there should be one Head to Health centre for every 50,000 to 70,000 people.[633] He suggested that Head to Health centres could be moulded to become the new front door for mental health rather than the public system or the EDs, and that would shift the system away from being a hospital based system. In the Commissioner's view, this could assist in managing the missing middle.[634] QAMH held a similar view:

> The federally-funded Head to Health centres, if scaled to demand, could potentially fill this role as community-based, easily accessible gateways to the mental health system and community wellbeing supports. QAMH acknowledges the intent of these centres, which is to provide a direct entry point and service the missing middle early in distress by providing short-term supports.[635]

QAMH added:

> We also appreciate the importance that has been placed on lived experience workers in the Head to Health centres, with the philosophy that 'Wellbeing Coaches' support people from when they arrive to when they are ready to leave, and clinicians are not the default providers of care. We keenly await the evaluation of these pilot centres, in particular whether they are able to reach the missing middle and cope with demand, how they balance clinical versus nonclinical care, whether they can provide targeted wellbeing responses, and whether there are adequate funded services available for onward referrals.[636]

In relation to the Head to Health centres, the Queensland and Australian Governments signed a bilateral agreement on 31 March 2022, which will deliver more mental healthcare and suicide prevention services for Queensland.[637] The $260 million investment, including $150.9 million from the Commonwealth and $109.5 million from Queensland, has funding for new Head to Health adult mental health centres, including, but not limited to the following:

- **$49.9 million** to establish a network of new Head to Health adult mental health centres and satellites across Queensland with 5 new Head to Health centres and 7 satellites. These new services will address gaps in the mental health system, providing more integrated, seamless mental health care for adults and older adults. These are in addition to Queensland's first Head to Health centre that opened on 20 January 2022 in Townsville.
- **$21.5 million** to establish two new Head to Health Kids Hubs to improve access to multidisciplinary team care to children.

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630 Head to Health, 'Overview', https://www.headtohealth.gov.au/supporting-yourself/adult-mental-health-centres; Head to Health, 'Locations', https://www.headtohealth.gov.au/supporting-yourself/adult-mental-health-centres. See Townsville Head to Health, https://headtohealth.neaminational.org.au/townsville/townsville-head-to-health.

631 Queensland Health, public briefing transcript, 20 January 2022, pp 18-19.

632 *Service model for Head to Health adult mental health centres and satellites*, revised June 2021, https://consultations.health.gov.au/mental-health-services/adult-mental-health-centres/results/revisedheadtohealthcentresandsatellitesservicemodeljune2021.pdf.

633 Public briefing transcript, Brisbane, 20 January 2022, p 30.

634 Public briefing transcript, Brisbane, 20 January 2022, pp 28, 30.

635 Submission 119, p 15.

636 Submission 119, p 15.

637 Queensland Health, tabled paper, public hearing, Brisbane, 29 April 2022.

- **$75.3 million** to enhance headspace centres to increase access to multidisciplinary youth mental health services in Queensland, with the Commonwealth funding the establishment of 2 new headspace sites and Queensland providing funding for clinical in-reach into new and existing headspace sites.
- **$10.3 million** to improve perinatal mental health screening and enhance capture and reporting of national consistent perinatal mental health data.
- **$10.5 million** to support additional initiatives that address gaps in the system of care for the 'missing middle'.[638]

Committee comment

The committee is pleased to see the additional Queensland and Australian Government funding aimed at supporting the mental health and wellbeing of Queenslanders, addressing services gaps for the 'missing middle' and decreasing the pressure at the acute end of the care continuum.

The committee heard evidence of the success of the co-responder programs in assisting people in their homes, which results in fewer presentations to EDs. In this regard, the committee recommends the Queensland Government expand this program and considers expansion into other metropolitan areas, such as Rockhampton. The committee believes that non-metropolitan areas, particularly in rural and remote Queensland, should also have access to similar support but acknowledges that the resources required may not be available. The committee recommends that the Queensland Government coordinates across HHSs, QAS and QPS to develop potential alternatives to the co-responder model in non-metropolitan areas.

Recommendation 28 – Expand co-responder model and develop and implement alternatives

The committee recommends the Queensland Government:

a) expands the current co-responder program, and considers expansion into other metropolitan areas, such as Rockhampton.

b) coordinates across Hospital and Health Services, the Queensland Ambulance Service, and the Queensland Police Service the development and implementation of potential alternatives to the co-responder model in non-metropolitan areas.

6.4.3 Suicide

Suicide Prevention Australia advised that 759 Queenslanders died by suicide in 2020 and that 'suicide is complicated, multi-factorial human behaviour with many varied and complex risk factors'. As social determinants of health and wellbeing, including social, economic and physical environments 'play a critical role in suicide rates', Suicide Prevention Australia stated that addressing these are 'key to meaningful reductions in suicide rates.[639] Suicide Prevention Australia explained this includes addressing:

> … early life, whole-of-person opportunities across Queensland Government responsibilities ranging from early childhood development, education and child protection through to key areas of family and domestic violence, alcohol and other drugs and housing.[640]

[638] Australian Department of Health, media release, 'New agreement to deliver more mental health and suicide prevention services for Queensland', https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/new-agreement-to-deliver-more-mental-health-and-suicide-prevention-services-for-queensland.

[639] Submission 25, pp 5, 7, 13.

[640] Submission 25, p 13.

The QMHC provided additional context for suicide rates in Queensland:

> There is no single factor that contributes to suicidal behaviour. Suicide is best understood as a complex interaction of individual, social and contextual factors. While suicide rates fluctuate from year to year, rates have increased over the last decade. More than 650 people die by suicide each year in Queensland.
>
> …
>
> It is estimated that for each person that dies by suicide, approximately 20 people attempt suicide. The impacts of suicide are immediate, far reaching and long lasting. They are felt by families, friends, work colleagues and the broader community, who may struggle to support a person experiencing suicidal behaviour, or to cope with the aftermath of a suicide.[641]

Suicide Prevention Australia also advised:

> On average, there were 209 suicide related calls to Queensland Police Service or the Queensland Ambulance Service every day for the period 2014-17, and 96% of individuals who had a suicide related contact with police or paramedics had contact with an ED. 36% of people who died by suicide and had prior suicide-related contact with police or paramedics had been alive in the month following their contact with police or paramedics, indicating significant risk for suicide re-attempt and death.[642]

Roses in the Ocean, a national lived experience of suicide organisation, emphasised the complex nature of suicide and the difference between mental ill-health and suicide:

> It is really important that people understand the difference between mental health and suicide. Obviously, there is an overlap; there are absolutely people who find themselves looking to end their life whose underlying causal factor is a mental illness. However, there are a lot of people whose causes are coming from relationship breakdown, housing issues, financial stresses—there are all sorts of other social determinants that come into play.
>
> Suicide is incredibly complex. It is as complex and as unique as the people, as human beings.[643]

Suicide Prevention Australia agreed, stating:

> Many individuals who attempt or die by suicide may not have a mental health condition and most individuals who have a mental health condition may never experience suicide ideation or a suicide attempt.
>
> Suicide prevention and mental health systems, services and policies are distinct but interrelated. There are unique issues facing both sectors yet also shared priorities around workforce, lived experience and awareness. There is also an overlap between many researchers, government agencies and service providers.
>
> Given the interconnection between these two issues, policy reform offers mutually beneficial outcomes for both mental health and suicide prevention.[644]

Suicide Prevention Australia noted that 'only half of those whose lives are lost to suicide in Australia each year are accessing mental health services at the time and around half of those who die by suicide each year have a diagnosed mental health condition'.[645]

6.4.3.1 Suicide prevention

Stakeholders made a number of recommendations in regard to suicide prevention in Queensland.

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641 Queensland Mental Health Commission, *Shifting Minds – Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018-2023*, p 11. NB: in-text referencing removed. Refer to original source for more information.

642 Submission 25, pp 7-8. NB: in-text referencing removed. Refer to original source for more information.

643 Public hearing transcript, Brisbane, 18 February 2022 p 4.

644 Submission 25, p 2. NB: in-text referencing removed. Refer to original source for more information.

645 Submission 25, p 2.

Aboriginal and Torres Strait Islander peoples

The committee notes the following grim suicide statistics for Aboriginal and Torres Strait Islander peoples:

- Aboriginal and Torres Strait Islander peoples 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.
- For Aboriginal and Torres Strait Islander peoples, the median age of death by suicide is approximately 29.5 years, compared to 45.4 years for non-Indigenous Australians.[646]

Suicide Prevention Australia also advised that Aboriginal and Torres Strait Islander peoples are 'more likely to be bereaved or impacted by suicide and are at higher risk of reporting multiple suicide exposures'.[647]

Suicide Prevention Australia highlighted that the concept of suicide among Aboriginal and Torres Strait Islander communities can differ from Western ideology, 'which is why culturally appropriate suicide prevention strategies that are co-designed and delivered by Aboriginal-controlled organisations or providers is critical'.[648]

The QFCC agreed that 'there needs to be a clear focus on ensuring equitable access to trauma-informed, culturally safe mental health services for Aboriginal and Torres Strait Islander children, young people and families' to overcome the current lack of culturally safe services across the continuum of support. The QFCC also agreed that these 'services must be designed and delivered in partnership with communities to meet the needs of the children and families they support'.[649]

In this regard, Suicide Prevention Australia recommended the Queensland Government 'invest in Aboriginal-led and culturally appropriate models improving Aboriginal and Torres Strait Islander experiences with mental health and suicide prevention services'.[650]

CALD community

As noted previously, CALD communities are at greater risk of poor mental health outcomes.[651] The QMHC stated that people from 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.'[652]

To support positive health outcomes, Lived Experience Australia recommended targeting specific programs for the CALD community.[653] The QMHC also recommended developing new and additional funding streams to support enhanced flexibility and responsiveness to the needs of people from CALD backgrounds.[654]

646 Queensland Mental Health Commission, submission 151, p 13. NB: in-text referencing removed. Refer to original source for more information.

647 Submission 25, p 20.

648 Submission 25, pp 20-21.

649 Submission 128, pp 13-14.

650 Submission 25, p 20.

651 Submission 12, p 6.

652 Submission 151, p 19.

653 Submission 12, p 7.

654 Submission 151, p 37.

The use of 'safe spaces' for suicide prevention

Suicide Prevention Australia stated that 'Safe Spaces are emerging as an important suicide prevention alternative to Emergency Departments'.[655] Suicide Prevention Australia continued:

> Many individuals experiencing suicidal thinking currently present to Emergency Departments yet these complex clinical environment are not the most appropriate point of care for people experience [sic] emotional distress and people with lived experience report distress can be exacerbated by this setting.
>
> Safe Spaces aim to provide an alternative and are an umbrella term referring to non-clinical, peer-led supports for people in suicidal distress and/or crisis. They are also known in some areas as safe havens or safe haven 'cafes'. Safe spaces are 'drop in' style spaces that offer a non-clinical alternative to acute, clinical services for people experiencing emotional distress or suicidal crisis. Safe spaces provide warm, welcoming environments in which to reduce distress and are staffed by suicide prevention peer workers with their own lived experience of crisis who can connect with others through the mutual understanding that comes with meaningful shared experience. They also connect guests of the service with other community supports including clinical support according to the guests wishes.[656]

In regard to safe spaces, Suicide Prevention Australia recommended:

- the Queensland Government expand safe spaces as alternatives to EDs for individuals experiencing suicidal thinking to ensure equity across HHSs with priority focus on creating safe spaces in regional and rural areas where services are limited.
- that the network of safe spaces includes different tiers of services to support individuals at different times and with different needs.[657]

According to Suicide Prevention Australia, the extended model of safe spaces includes:

- Tier 5: a non-clinical peer run resident safe house where people in crisis can stay for multiple days supported by suicide prevention peers with lived experience
- Tier 4: a non-clinical peer run safe alternative to emergency departments with a suicide prevention focus, staffed by suicide prevention peers with lived experience
- Tier 3: a safe space to access psychosocial support and safety planning — primarily existing mental health services enhanced with peer workers
- Tier 2: a safe space to talk to someone and access a referral (eg community centres/services/chemist) in settings that are already operating with staff who are trained to identify risks and connect people to supports
- Tier 1: a safe 'refuge' to sit in (eg library, coffee shop, hairdresser, barber) that are community based non-clinical supports.[658]

Suicide Prevention Australia submitted that there is particular need for investment in tiers 4 and 5.[659]

Ms Pattison made the following recommendations in relation to safe spaces:

- provide alternatives to EDs that are open on weekends, outside of business hours and for patients that are needing crisis support but can be seen in a non-ED setting.

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655 Submission 25, p 9.

656 Submission 25, p 9. NB: in-text referencing removed. Refer to original source for more information.

657 Submission 25, p 9. NB: NB: in-text referencing removed. Refer to original source for more information.

658 Submission 25, p 10.

659 Submission 25, p 10.

- these alternatives need to have an aspect of peer support to ensure a nonjudgmental, healing way to talk through crisis rather than being assessed by a doctor whose perceptions of crisis may be vastly different to the patients.[660]

Adopting a lived experience leadership approach

Suicide Prevention Australia called for 'lived experience leadership, knowledge and insights [to] be integrated in all aspects of suicide prevention', and added:

> Survivors of suicide attempts, carers and the bereaved are all uniquely placed to inform suicide prevention and postvention and are essential to ensuring policies and practice meet the needs of those at-risk or impacted by suicide.[661]

Training and resourcing

At the acute end of care, Lived Experience Australia recommended that training be provided for 'Emergency Department staff in mental health, suicide training and how to interact with people with lived experience and their carers/families'.[662]

Suicide Prevention Australia also recommended the Queensland Government:

> Expand and appropriately resource specialist mental health clinicians in both police districts and within ambulance call out teams across all Hospital and Health Services (HHS) in Queensland to ensure equity, build prevention capability, and aligned with Queensland Suicide Prevention Plan action for a state-wide co-responder model linking Queensland Police Service, Queensland Ambulance Service and Queensland Health.
>
> …
>
> Strengthen the mental health and suicide prevention workforces by not only increasing availability of staff, but ensuring appropriate infrastructure is in place to enable integration of both clinical and non-clinical workforces to enhance continuity of care between professionals and treating teams.[663]

Early intervention

The Zero Suicide Institute of Australasia highlighted that 'access to a continuum of integrated services is a critical component of early management of mental ill-health'.[664] Lived Experience Australia agreed and recommended:

- expanding identification, early intervention, and suicide prevention activities in rural and remote communities, Aboriginal and Torres Strait Islander communities, with funding to local government to promote good mental health and wellbeing and suicide prevention.
- expanding programs targeting first responders to maintain their mental health and wellbeing as well as identification, early intervention, and suicide prevention.[665]

660 Submission 159, p 6.

661 Submission 25, p 18.

662 Submission 12, p 4.

663 Submission 25, p 3.

664 Submission 67, p 4.

665 Submission 12, p 7.

After care

Lived Experience Australia stated that 'half of consumers who accessed an emergency department in crisis and were discharged without being admitted, did not have follow up or receive referrals after discharge' and that 'some attempted or suicided after discharge'.[666]

In regards to after care, Suicide Prevention Australia recommended that the Queensland Government:

> Enhance and strengthen follow up procedures for people discharged into the community after a mental health and/or suicidality related presentation to ensure vulnerable Queenslanders are connected and engaged with community-based supports.[667]

Committee comment

The committee notes that the Bilateral Schedule is providing funding for the following suicide prevention services:

- **$78.6 million** to expand and enhance existing universal aftercare services to support individuals following a suicide attempt and / or suicidal crisis.
- **$9.4 million** to ensure all people in Queensland who are bereaved or impacted by suicide can access postvention support services.
- **$4.9 million** to implement a Distress Intervention Trial Program to prevent and reduce suicidal behaviour.[668]

The committee has heard that many individuals experiencing suicidal ideation present to EDs, yet these complex clinical environments are not the most appropriate point of care for people experiencing emotional distress, and people with lived experience report distress can be exacerbated by this setting.[669]

The committee agrees that 'warm entry points' and 'safe spaces' like those provided by Oasis Crisis Care in Hervey Bay offer opportunities to meet the health and wellbeing needs of persons experiencing a mental health crisis and divert them from EDs.

The committee supports the view that community-based 'safe spaces' operating at different tiers also offer an alternative to treatment at EDs for people experiencing a mental health crisis. The committee heard that there is a need for investment in tier 4 and 5 safe spaces and that early intervention community-based services contribute to fewer presentations at EDs.[670]

The committee supports the views of stakeholders that more can be done to prevent suicide in Queensland and makes the following recommendations.

666 Lived Experience Australia, *The 'missing middle' lived experience perspectives*, 2021, https://www.livedexperienceaustralia.com.au/research-missingmiddle, p 3.

667 Submission 25, p 3.

668 Australian Department of Health, media release, 'New agreement to deliver more mental health and suicide prevention services for Queensland', https://www.health.gov.au/ministers/the-hon-greg-hunt-mp/media/new-agreement-to-deliver-more-mental-health-and-suicide-prevention-services-for-queensland.

669 Suicide Prevention Australia, submission 25, p 9.

670 Suicide Prevention Australia, submission 25, pp 9-10.

Recommendation 29 – Implement oustanding suicide prevention strategies

The committee recommends the Queensland Government implements all outstanding suicide prevention strategies within the *National Mental Health and Suicide Prevention Plan* and *The Queensland Suicide Prevention Plan 2019-2029: Phase One*.

Recommendation 30 – Expand alternative entry points and emergency department diversion services

The committee recommends the Queensland Government expands alternative entry points and emergency department diversion services, including consideration of all tiers of the extended model of safe spaces at hospitals and in the community, or other innovative models of care, giving consideration to extended hours of operation.

Recommendation 31 – Expand aftercare services for people discharged from healthcare settings

The committee recommends the Queensland Government increases aftercare services for people being discharged into the community after a mental health and/or suicidality related presentation.

6.5 Specific shortages of mental health and AOD beds and services

Numerous stakeholders acknowledged that there are specific shortages of mental health and AOD beds and services across Queensland. This section considers the need for enhanced non-acute and sub-acute services to alleviate pressure on acute care in Queensland, and the need for more inpatient mental health and AOD beds and services more broadly.

6.5.1 Adolescent and children's mental health beds

There are 66 adolescent mental health beds in Queensland across a number of HHSs with 9 child beds at the Queensland Children's Hospital.[671]

Children's Health Queensland Hospital and Health Service advised that more adolescent and children's mental health beds are needed but they must be located appropriately. Professor Stathis from Children's Health Queensland HHS stated that 'families do not want their very unwell young person to be transferred hundreds, sometimes thousands, of kilometres away'. He elaborated:

> There are eight adolescent acute beds in Townsville and the flow is from Cairns and from Mackay, but anywhere between 80 per cent and 90 per cent of young people are admitted locally into the Cairns Hospital and Mackay Hospital. Although there are no dedicated adolescent beds and no dedicated funding for them, the reality is that that is where they get the best care close to home. It is not that they will not get care at Townsville, but parents—and I am a parent—understandably do not want their kids transferred.
>
> The other important thing for many adolescents—and I am not discounting the distress and suicidality that they experience—is that many adolescents recover quite quickly, unless they have an evolving psychotic illness for instance. If they become acutely suicidal, it is not uncommon that they only need two or three days in hospital. You do not want to transfer your child far, far away to another hospital for a couple of days and come back.[672]

[671] Children's Health Queensland Hospital and Health Service, public hearing transcript, Brisbane, 11 February 2022, p 15.

[672] Public hearing transcript, Brisbane, 11 February 2022, p 15.

Professor Stathis also commented on wait times for an acute bed:

> … it is not uncommon to have significant stress on adolescent beds and for people to be waiting 24 or 48 hours. I know that last year there was a young person who waited in an emergency department for over three days for an acute bed.[673]

In its role to support children and young people, the QFCC expressed concern that the 'demand for mental health treatment has long outstripped the available supply in Australia'.[674] The QFCC was concerned about availability of step-down services from inpatient care for this demographic:

> Capacity and capability shortages have sparked concerns about limited access to treatment and premature discharge to manage pressure for mental health beds, exacerbating challenges caused by a lack of safe accommodation options and step-down services available for vulnerable children and young people.[675]

Committee comment

The committee acknowledges that the lack of mental health beds for children and young people is an issue for service delivery in Queensland, and, for this reason, the committee recommends that the Queensland Government increases the availability of children and youth mental health beds in Queensland.

Recommendation 32 – Expand child and youth mental health services

The committee recommends the Queensland Government:

a) increases child and youth mental health inpatient beds and services, particularly in regional Queensland.

b) reviews discharge planning for children and young people, particularly with regards to school re-integration.

6.5.2 Adult mental health beds

In 2020-21, Queensland had 32.3 beds per 100,000 persons across hospital and community residential services.[676] In 2019-20, Queensland had the lowest number of beds per 100,000 at 32.0 beds per 100,000 against the national average of 37.1 beds per 100,000.[677]

The bed numbers are made up of hospital beds (1,312 average available beds at a point in time) and 24-hour staffed residential mental health beds (329 average available beds).[678] Queensland Health advised:

> The majority of beds (53 per cent) are in the acute admitted setting, 27 per cent are in extended admitted (including forensic and secure rehabilitation beds) and the remaining 20 per cent are in community residential services.[679]

673 Public hearing transcript, Brisbane, 11 February 2022, p 15.

674 Submission 128, p 15.

675 Submission 128, pp 15-16. NB: in-text referencing removed. Refer to original source for more information.

676 Queensland Health, briefing paper, 1 February 2022, p 17.

677 Queensland Health, briefing paper, 1 February 2022, p 17.

678 Queensland Health, submission 150, p 18.

679 Queensland Health, briefing paper, 1 February 2022, p 17.

Queensland has a shortage of inpatient beds, particularly for acute admission.[680] Queensland Health added:

> For inpatient hospital beds, Queensland remains below the national average of 27.5 public MH [mental health] hospital beds per 100,000 population at 25.5. However, this is a slight increase from the 25.3 in 2018-19. While there has been an increase in residential MH beds in 2019-20 of 6.4 beds per 100,000 population up from 5.6 in 2018-19, Queensland remains below the national average of 9.5 residential MH beds per 100,000.[681]

As it is acknowledged that mental ill-health will affect some people to a degree that they will require acute care for periods of time within authorised mental health facilities rather than the community,[682] a number of stakeholders expressed concern about this shortage of mental health beds.[683]

Queensland Health also noted the impact of lack of access to community placement:

> … not being able to access community placements can mean a longer than required inpatient admission or stay in the ED or not having the right type of treatment/ beds along an individual's treatment and recovery can impact their mental health/AOD outcomes.[684]

Similarly, Professor Whiteford commented that a lack of subacute beds would increase the likelihood that a person requiring treatment would need to be admitted into an acute setting earlier:

> In the model the Productivity Commission did, the subacute beds were much more undersupplied than the acute beds. If you do not have a subacute bed, someone will get admitted earlier and they will stay longer because there is no step-down service for them to go to or they will be discharged prematurely, their condition will relapse and they will be readmitted. The number of beds is not just an absolute number; it is a number dependent upon what other services are available in the continuum from early intervention, primary care, specialist care in the community right through to the bed based services.[685]

The QMHC also agreed, stating that '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'.[686]

6.5.2.1 Hospital in the home

During a site visit to the Wide Bay HHS, Mental Health and Specialised Services, the committee heard evidence of the benefits of outreach programs, specifically the 'Hospital in the Home' (HITH) program operating in Hervey Bay. HITH, or home-based assertive treatment, is used to provide short-term, home-based acute care as an alternative to inpatient care. HITH care is designed for consumers who are suitable to receive care, treatment, and support in their own home.[687]

680 Queensland Health, submission 150, p 7.

681 Queensland Health, submission 150, p 18.

682 The Public Advocate, submission 143, p 2.

683 See, for example, Queensland Family and Child Commission, submission 128; RANZCP Queensland Branch, submission 140; Mater Health – Perinatal Mental Health, submission 144.

684 Queensland Health, submission 150, p 15.

685 Public hearing transcript, Brisbane, 17 February 2022, p 31.

686 Submission 151, p 3.

687 Submission 150, p 86.

The 'level of care is equivalent to being in hospital' with services including medical, nursing, physiotherapy, occupational therapy, dietetics and speech pathology.[688] HITH allows consumers to remain connected to family and routine while receiving high intensity care.[689]

According to Queensland Health, home-based treatment teams are a core recommendation from the *National Confidential Inquiry in Suicide and Homicide* in the United Kingdom to provide evidence-based, safer care. Apart from a few examples of home-based treatment, this has not yet been a focus of funding in Queensland.[690]

The RANZCP Queensland Branch described an example of hospital in the home services operating out of the Royal Brisbane and Women's Hospital:

> The one area where we are reasonably starting to restart is hospital in the home. There are a lot of people who can be treated assertively in their home. If the person is not at high risk to themselves and they have a supportive carer, you can send staff out. We started at Royal Brisbane about three or four years ago—a small, home based acute care service whereby we have two staff, two shifts a day, and a psychiatrist and they can manage about six or seven people with depression. The staff will go out and see them every day. The psychiatrist will go out and see them twice a week. That is very effective. It saves hospital beds. The patients like it. If that does not work, you can then steer into the step-up step-down facilities rather than going to the acute inpatient units.[691]

6.5.3 Perinatal mental health beds

In relation to perinatal mental healthcare, Mater Health - Perinatal Mental Health stated that with only 4 dedicated public perinatal mental health beds available to support over 12,000 births per annum, there is a devastating gap in the ability of the Queensland health system to meet the needs of the community. Mater Health - Perinatal Mental Health added:

> The stark void in perinatal mental health services in Queensland is larger than for any other state in Australia, with limited or poor quality perinatal mental health care, support and treatment.[692]

The RANZCP Queensland Branch echoed the concern about a lack of appropriate mental health beds to which a mother can be admitted for treatment without separation from her baby.[693]

Mater Health—Perinatal Mental Health advised the committee:

> Every year almost 1,000 mothers with children under 12 months of age will present to Queensland emergency services in a suicidal crisis. Despite the prevalence of these presentations, mental health conditions during the perinatal period often go undetected an untreated. If untreated, perinatal mental health issues can result in long-term emotional and social wellbeing impacts for the parent, child and families and, in some cases, perinatal mental illness can result in maternal suicide or infant death. Maternal suicide is the leading cause of death for women in the perinatal period.
>
> The recommended ratio for specialist mother-baby beds is one bed per 1,500 to 1,600 births. Using this formula, Queensland should provide between 38 to 40 dedicated beds for mothers and babies in Queensland. There are currently four mother-baby beds in Queensland, equating to one bed per 15,000 births. By comparison, in Victoria there are 33 operational beds in six public units. This equates to one bed to every 2,300 births.[694]

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688 Queensland Health, 'Hospital in the Home', https://www.health.qld.gov.au/sunshinecoast/community/hith.

689 Submission 150, pp 86-87.

690 Submission 150, pp 86-87.

691 RANZCP Queensland Branch, public hearing transcript, Brisbane, 12 April 2022, p 66.

692 Submission 144, p iii. NB: in-text referencing removed. Refer to original source for more information.

693 Submission 140, pp 15, 18.

694 Public hearing transcript, Brisbane, 13 April 2022, p 48.

Queensland Health has identified more beds across inpatient acute, sub-acute and non-acute extended treatment services are needed.[695]

Committee comment

The committee notes that Queensland has a shortage of adult mental health beds and that further resources at the non-acute and sub-acute stages of mental healthcare would reduce the reliance on the critical end of the spectrum. The committee acknowledges the need for alternatives to hospitalisation and supports the use of the home-based acute care model of HITH.

The committee is of the view that there is a need for more adult mental health beds and HITH options should be increased.

Recommendation 33 – Expand provision of Hospital in the Home care model

The committee recommends the Queensland Government increases Hospital in the Home options of mental health support.

Recommendation 34 – Expand adult mental health services

The committee recommends the Queensland Government expands the availability of adult mental health beds and services in Queensland.

Committee comment

Given the evidence shows that the first 2000 days of life profoundly impact a person's mental health across their lifetime, and that 1 in 5 mothers and 1 in 10 fathers will experience either anxiety or depression in the perinatal period, the committee supports enhanced services that support parents and their children, particularly at this crucial time. The committee notes that there is an undersupply of perinatal beds in Queensland in contrast to the number of births.

For these reasons, the committee recommends the Queensland Government expands the availability of perinatal and infant mental health beds and services in Queensland.

Recommendation 35 – Expand perinatal and infant mental health services

The committee recommends the Queensland Government expands the availability of perinatal and infant mental health beds and services in Queensland, including community-based solutions.

6.5.4 Psycho-geriatric beds

Queensland has 16 long-stay psycho-geriatric beds in nursing homes. According to the RANZCP Queensland Branch, this number represents too few psycho-geriatric beds, resulting in older persons occupying acute mental health beds in general adult mental health wards across Queensland public hospitals, often for prolonged periods of time.[696]

The RANZCP Queensland Branch also stated that Queensland has a low number of community-based psycho-geriatric mental health staff. In this regard, the RANZCP Queensland Branch recommended more acute psycho-geriatric beds and at least 3 long-stay psycho-geriatric beds, as well as an increase

695 Submission 150, p 123.

696 Submission 140, pp 15, 18.

in state funding to support community mental health staff with specific workforce expertise to care for psycho-geriatric mental health presentations in the community.[697]

The Queensland Government recognises that improvement is needed and is focused on 'continuing to build and strengthen partnerships with geriatric medicine and aged care'.[698]

In this regard, the committee acknowledges the work of the Royal Commission into Aged Care Quality and Safety with recommendations that addressed matters relating to the mental healthcare of older persons, including, but not limited to:

- integrating long-term support and care for older people
- embedding high quality aged care that shall:
    - be provided on the basis of a clinical assessment, and regular clinical review, of the person's health and wellbeing, and that the clinical assessment will specify care designed to meet the individual needs of the person receiving care, such as risk of falls, pressure injuries, nutrition, mental health, cognitive impairment and end-of-life care
    - enhance to the highest degree reasonably possible the physical and cognitive capacities and the mental health of the person
- establishing a dementia support pathway and consider specialist dementia care services, including:
    - ensuring that the specialist dementia service it funds provides treatment to people with a mental health condition if they meet other eligibility criteria (including, for instance, a diagnosis of dementia)
- ensuring care at home includes a level of allied health care appropriate to each person's needs … to restore their physical and mental health to the highest level possible (and maintain it at that level for as long as possible) to maximise their independence and autonomy
- increasing access to older persons mental health services, including:
    - funding separately, under the National Health Reform Agreement, outreach services delivered by State and Territory Government Older Persons Mental Health Services to people receiving residential aged care or personal care at home
    - introducing performance measures and benchmarks for these outreach services
    - promulgating standardised service eligibility criteria for hospital, community based, and aged care Older Persons Mental Health Services that do not exclude people living with dementia from eligibility for such services.[699]

Committee comment

It is the view of the committee that more work needs to be done to support the mental health and wellbeing of older persons in Queensland. For this reason, the committee recommends that the Queensland Government: a) explore ways for HHSs to support the implementation of the recommendations of the 2021 Royal Commission into Aged Care Quality and Safety; b) increase Older

697 Submission 140, pp 15, 18.

698 Submission 150, p 123.

699 Royal Commission into Aged Care Quality and Safety, *Final Report – List of Recommendations*, https://agedcare.royalcommission.gov.au/sites/default/files/2021-03/final-report-recommendations.pdf.

Persons Mental Health Services in HHSs; and c) consider implementing HITH services for persons who reside in aged care facilities.

Recommendation 36 – Expand and improve older persons mental health services

The committee recommends the Queensland Government:

a) explores ways for Hospital and Health Services to support the implementation of relevant recommendations of the 2021 Royal Commission into Aged Care Quality and Safety.

b) increases Older Persons Mental Health Services in Hospital and Health Services.

c) considers using Hospital in the Home services for persons who reside in aged care facilities.

6.5.5 Alcohol and other drugs beds

In the Hospital Alcohol and Drug Service unit at the Royal Brisbane and Women's Hospital, there are 16 specific HHS delivered inpatient AOD withdrawal beds. NGOs and Aboriginal and Torres Strait Islander Community Controlled Health Organisations also deliver residential rehabilitation and residential withdrawal management AOD treatment. Queensland Health funds 8 NGOs to deliver these services across several sites in Queensland. An estimated 674 residential AOD treatment beds in Queensland are funded from a variety of sources including 'self-generated revenue, client contribution, philanthropy and funding by governments including the Commonwealth Government'.[700]

The Queensland Government is funding new adult residential rehabilitation and withdrawal management services in Bundaberg (28 beds) and Ipswich (45 beds), and a new youth AOD residential treatment service (10 beds) in Cairns. The service in Rockhampton (42 beds) commenced operation in December 2021.[701]

Queensland Health's *The health of Queenslanders 2020*, states:

> In Queensland, specialist public sector mental health, alcohol and other drug services are delivered through HHSs and funded non-government providers. Specialist alcohol and other drug services provide treatment for people living with substance use disorders. Treatment may include withdrawal management, pharmacotherapy, psychosocial intervention, rehabilitation and harm reduction services.
>
> In 2018–19, 180 publicly funded alcohol and other drug treatment agencies in Queensland provided 47,831 treatment episodes to 35,123 clients (97% of episodes were for their own alcohol and other drug use).[702]

Committee comment

The committee is pleased that the Queensland Government has identified the need for more adult residential rehabilitation and withdrawal management services in Queensland and has increased its funding for beds in certain locations. However, the committee is of the view that more can be done to support those seeking treatment for AOD issues across the whole of Queensland. In this regard, the committee recommends that as part of a regional planning process (see recommendations in section 6.6), the Queensland Government identifies further locations in Queensland requiring additional AOD withdrawal beds and services as needed.

700 Queensland Health, briefing paper, 1 February 2022, p 17.

701 Queensland Health, briefing paper, 1 February 2022, pp 17-18.

702 Queensland Health, *The health of Queenslanders 2020: report of the Chief Health Officer Queensland*, November 2020, p 70.

Recommendation 37 – Expand alcohol and other drugs inpatient services

The committee recommends the Queensland Government identifies locations in Queensland requiring additional alcohol and other drugs withdrawal beds and increases services as needed.

Committee comment

The committee recognises the importance of step up, step down and rehabilitation services for patients as they transition from AOD inpatient care. In this regard, the committee recommends that step up, step down and rehabilitation AOD services be expanded in Queensland.

Recommendation 38 – Expand availability of step up, step down and rehabilitation alcohol and other drugs services

The committee recommends the Queensland Government expands step up, step down and rehabilitation alcohol and other drugs services in Queensland.

Committee comment

The committee also supports an increase in beds for perinatal/AOD patients to support mother/parent and child treatment and, in this regard, recommends increasing residential rehabilitation services for this population group.

Recommendation 39 – Expand community-based alcohol and other drugs bed-based care

The committee recommends the Queensland Government increases the number of community-based alcohol and other drugs beds and expands residential alcohol and other drugs rehabilitation services for mothers/parents and their children.

Committee comment

To ensure consistency and quality assurance across the delivery of AOD services, the committee makes the following recommendation.

Recommendation 40 – Review regulation and accreditation requirements of alcohol and other drugs services

The committee recommends the Queensland Government reviews the regulation of alcohol and other drugs services provided by non-government organisations and the private sector, including standards of practice and the accreditation of staff.

6.6 Regional planning for delivering mental healthcare services and closing the gap on services

The committee heard evidence regarding the benefits of developing a regional planning approach to mental healthcare services for the purpose of addressing service gaps.

The Brisbane South PHN recommended, for example, that the Queensland Government, in consultation with PHNs and HHSs, develop a state and/or regional Perinatal Mental Health [plan] to ensure integrated service delivery and smooth transitions of care across the health system.[703] The World Wellness Group proposed that the Queensland Government work through the joint HHS/PHN

[703] Submission 87, p 4.

mental regional planning processes to ensure targeted approaches to the needs of local CALD Population.[704]

MIFA stated that regional planning would ensure 'that the diverse needs of communities can be adequately addressed and that additional psychosocial support places can be created'. MIFA further stated:

> Rural and remote communities, First Nations communities and CALD communities have different needs. By effectively engaging consumers, families, carers, service providers, community leaders and other relevant stakeholders, regional planning is effective in co-designing the right mix of services for each community. Once the level of need has been estimated, funding for psychosocial supports should be matched to the level of need across Queensland.[705]

The committee notes that the Royal Commission into Victoria's Mental Health System recommended moving towards integrated regional governance, which included recommending establishing 8 interim regional bodies to provide advice to the Victoria Department of Health (Victoria DoH) as it plans, develops, coordinates, funds and monitors a range of mental health and wellbeing services in each region.[706]

The Victoria DoH advised that Victorian HHSs will have a role in planning for regional health service delivery. Ms Katherine Whetton of the Victoria DoH noted that there is still much work to do in this area but that in the first stages of the process the interim regional boards will 'work closely with health services to understand local needs'. The initial focus of the boards will be to 'build relationships with local communities and local stakeholders', with the approach to any planning involving extensive engagement.[707]

In regards to regional planning, Queensland Health stated:

> Under the Fifth Plan, all Governments signed up to the commitment for PHNs and HHSs to work together to achieve integrated regional planning and service delivery. Central to this action is the development of joint regional mental health and suicide prevention plans using nationally developed tools such as the NMHSPF [National Mental Health Service Planning Framework] to guide evidence-based decision making about the right mix and level of services and workforce to meet local needs. Joint regional plans are supported by implementation strategies outlining governance, change management, priorities, milestones, and success monitoring. An iterative process to the development of joint regional plans is advocated with PHNs and HHSs starting with foundational plans and developing more comprehensive plans as the partnership and collaboration matures.[708]

In regards to the NMHSPF, the committee notes the NMHSPF is an evidence-based framework, designed to support coordinated planning across Australia's mental health system. It helps providers of mental health services, such as PHNs, local hospitals, state and territory governments and the Australian government, identify the kind of services that are required, and how many people require those services.[709]

Queensland Health acknowledged that 'focusing on access to beds, co-responder models, and solutions within the ED are important but will be insufficient to solve the complex demands of crisis

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704 Submission 59, p 4.

705 Submission 88, p 15.

706 Royal Commission into Victoria's Mental Health System, *Recommendations*, https://finalreport.rcvmhs.vic.gov.au/recommendations/.

707 Public hearing transcript, Brisbane, 28 April 2022, p 3.

708 Submission 150, p 32.

709 Australian Government, Australian Institute of Health and Welfare, *National Mental Health Service Planning Framework,* https://www.aihw.gov.au/nmhspf/overview.

response - which requires system reform to ensure a connected continuum of care'. Queensland Health stated that what is required is a:

> regional response which constitutes a coordinated network of services … to meet the needs of those in crisis, including a continuum of care that prevents and intervenes prior to crisis, provides early intervention, coordinated crisis response, and supports recovery and relapse prevention following crisis. Important core principles need to be shared across these service elements.[710]

Queensland Health acknowledged the current limitations in the overall health care continuum that contributes to ED presentations, and advised that attention on the following priority areas will help to address these issues:

- development of a statewide crisis reform strategy and support for regional planning to align with this, and partner with the Commonwealth Government to ensure appropriate interface between state-funded specialised MH services and proposed new community Adult MH Centres.
- enhance resources available to acute care teams to enable optimal care and follow up, including home and community outreach, acute mobile response, and home-based treatment, and expand the role of peer workers in EDs, home and community outreach.
- enhancing Drug and Alcohol Brief Intervention Teams providing services to EDs.
- establish additional crisis stabilisation services in areas with highest ED demand as alternatives to EDs, and crisis support spaces in all major hospitals or in accessible community locations close by, with extended operating hours as an adjunct to EDs.
- enhancing Drug and Alcohol Brief Intervention Teams providing services to EDs.
- establish crisis care co-ordination roles to improve co-ordination and follow-up care for people presenting to emergency and acute care teams in crisis.
- enhancement of the Police Communications MH Liaison Service (eg expanding operating hours, referral pathways, improved links to the broader crisis system).
- enhanced MH Services funding to provide a stepped care approach to care for people with Personality Disorder, to enable the provision of brief interventions for people presenting in crisis, group work and individual therapy.
- enhanced funding to provide short stay pathways within acute inpatient units maximise the use of existing MH beds, provide more intensive evidence-based interventions and peer workforces support for those people requiring brief crisis admission given infrastructure delays to building new beds.[711]

Committee comment

The committee is of the view that reviewing services, needs and capacity at a regional level and then designing and delivering mental healthcare services based on a regional planning approach will create efficiencies, enhance person-centred mental healthcare, and address the 'missing middle'.

While the committee acknowledges that the aim of the *National Mental Health Service Planning Framework* is to coordinate planning across Australia's mental health system, including the joint regional planning that currently occurs between HHSs and PHNs, the committee believes developing overarching regional mental healthcare plans for Queensland would be beneficial and, in this regard, makes the following recommendations.

[710] Submission 150, p 82.

[711] Submission 150, pp 88-89

Recommendation 41 – Apply governance principles for regional mental healthcare planning

The committee recommends that, in considering the recommendations in Chapter 6 regarding delivering mental healthcare and alcohol and other drugs services as part of a regional planning process, the Queensland Government:

a) applies overarching governance principles in a standard format.

b) co-designs and uses appropriate governance models for Aboriginal and Torres Strait Islander communities as part of the process.

c) collaborates with people with lived experience as part of the regional planning process.

d) clearly documents funding commitments and, as part of the governance structure, monitors services delivered against those funding commitments.

e) reviews the Victorian Department of Health's regional planning model and considers it for application in Queensland.

Recommendation 42 – Develop mental healthcare regional plans

The committee recommends the Queensland Government develops mental healthcare regional plans, with consideration to:

a) applying recommendation 23 of the Productivity Commission, which states—

Governments should strengthen cooperation between Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) by requiring comprehensive joint regional planning and formalised consumer and carer involvement.

b) engaging with the following stakeholders in the development of the plans: Hospital and Health Services; private hospitals; primary health networks; community stakeholders; people with lived experience and their families, carers and support persons; non-government organisations; community controlled health organisations; Queensland Departments of Education and Housing; Australian Government Department of Veterans' Affairs; National Disability Insurance Scheme administrators and managers; Health & Wellbeing Queensland; the Queensland Mental Health Commission; the Mental Health Branch of Queensland Health; and local governments.

c) referencing services across the continuum of mental healthcare and alcohol and other drugs, and ensure services are responsive to the needs of at-risk groups, with consideration given to those groups identified in section 5.5 of this report.

d) considering the mental health and alcohol and other drugs services required across an individual's lifespan, including but not limited to, early psychosis services to support children and young people, as well as mental healthcare services for individuals within perinatal and infant, adult, and older persons population groups.

e) prioritising consideration of strategies to address the 'missing middle' services gap.

f) clearly identifying which agency is funding which aspect of the plan.

g) in relation to Aboriginal and Torres Strait Islander discrete communities, establishing the community controlled health organisation as the lead agency for service delivery, workforce planning and funding; and in other locations with Aboriginal and Torres Strait Islander populations, establishing a sub-regional plan led by the community controlled health organisation.

7 Mental health workforce

Across all Australian states and territories, demand for mental health support and treatment has steadily increased over time and outstrips the available supply. The factors constraining the supply of support and treatment are diverse. They include the lack of an appropriately skilled workforce able to provide support and treatment when, where and how consumers and carers prefer.[712]

The functioning of the mental health service system depends on the availability of high-quality workers with the right skills, who are allocated to tasks that use their skills efficiently.[713]

The National Mental Health Workforce Taskforce identified the following workforce challenges:

- a shortage of workers across most occupations providing support and treatment to people experiencing suicidality, mental distress and/or ill-health
- the mental health workforce is maldistributed
    - geographically, with more acute shortages in regional and remote locations
    - between service settings such as public, private and community-based (including those providing psychosocial supports) settings
    - within occupations, with some areas of specialisation experiencing more significant shortages than others
- the current mental health workforce is not always appropriately skilled, as not all workers have updated their practice to reflect contemporary approaches that support culturally safe, trauma informed, sustainable, recovery oriented, integrated support and treatment
- not all occupations operate to their full scope of practice, reducing the opportunities afforded to the available workforce, including emerging occupations.[714]

These factors impact on access to and quality of support and treatment available to consumers, carers and their families.[715]

This chapter outlines the challenges facing the mental health workforce, including the reported barriers to attracting and retaining a skilled mental health and AOD workforce.

Mental health workforce planning and development are then considered, including submitters' views as to how to leverage the allied health and lived experience workforces. Finally, this chapter considers how state-funded mental health services are meeting consumer needs and the cultural capability of the mental health and AOD workforce.

712 Australian Government Department of Health, National Mental Health Workforce Strategy Taskforce, *National Mental Health Workforce Strategy – Consultation Draft*, August 2021, p 1.

713 Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 699.

714 Australian Government Department of Health, National Mental Health Workforce Strategy Taskforce, *National Mental Health Workforce Strategy – Consultation Draft*, August 2021, p 1.

715 Australian Government Department of Health, National Mental Health Workforce Strategy Taskforce, *National Mental Health Workforce Strategy – Consultation Draft*, August 2021, p 1.

7.1 Diversity of mental health workforce

The Australian mental health workforce is large, diverse, dynamic, evolving and difficult to define. While mental health workforce definitions are much debated, there is general agreement about specialist, generalist and lived experience as 3 distinct but inter-related workforces.[716]

Queensland's mental health workforce is made up of a range of occupational groups and titles consistent with those identified by the Productivity Commission:

- **Medical practitioners** include:
    - **GPs** provide primary healthcare in community settings. They are often the first point of contact for someone with a health problem; may provide lower-intensity psychological therapies; and manage a person's overall health, including referrals for specialist treatment.
    - **Psychiatrists** specialise in the diagnosis and management of more complex and severe mental illness, using psychological and medical treatments.
- **Psychologists** provide assessment and therapy to people experiencing mental ill-health.
- **Nurses** perform tasks in the assessment and management of people's health.
    - There are 3 types of nurses – **enrolled nurses** (diploma-level training), **registered nurses** (undergraduate degree) and **nurse practitioners** (post-graduate).
    - **Specialist mental health nurses** are registered nurses who have undertaken advanced training in mental health.
- **Community mental health workers** generally work for NGOs, delivering psychosocial support services on behalf of government in a non-clinical setting.
- **Lived experience (peer) workers** are employed because of their own experiences with mental illness and recovery.[717]
- **Allied health professionals** are university-qualified practitioners with specialist expertise related to physical or mental health (eg occupational therapists, social workers, psychologists, pharmacists, and counsellors).

  The **Aboriginal and Torres Strait Islander workforce** emerged in response to the need for culturally capable support for Aboriginal and Torres Strait Islander peoples whose needs were not being met by mainstream services. This workforce is clinical and non-clinical. [718]

[716] Cleary, Anne, Thomas, Natalie, and Boyle Fran. Institute for Social Science Research, The University of Queensland, *National Mental Health Workforce Strategy - A literature review of existing national and jurisdictional workforce strategies relevant to the mental health workforce and recent findings of mental health reviews and inquiries*, 29 July 2020, p 7.

[717] This includes peer workers who use their own experience of mental ill-health to provide emotional and practical support to people experiencing mental illness, and carer peer workers who provide an analogous role for carers of people with mental ill-health.

[718] Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 702.

7.1.1 Queensland Health's MHAOD Branch workforce

According to Queensland Health, Queensland is the only public health service to integrate mental health and AOD at an administrative level which it has done for 'about 10 years'.[719]

Queensland Health explained the rationale for integrating the treatment of mental ill-health and AOD:

> The policy, planning and strategic functions for MH and AOD have been organisationally combined since 2012. Prior to that, these were separate functions within the DoH. This shift recognises the need for policy, planning and funding approaches to support integrated and aligned treatment and service responses, including for individuals who have both a mental illness and problematic substance use[720].

The MHAOD Branch workforce consists of a range of clinical and non-clinical staff across HHS including:

> … nurses, allied health professionals (psychologists, occupational therapists, social workers), psychiatrists, addiction medicine specialists, rural generalists (medical and allied health), allied health and nursing assistants, Aboriginal and Torres Strait Islander Health Workers, lived experience (peer) workers, psychosocial support workers and administrative, policy, program and support staff.[721]

In 2020-21, there were:

- 7,548.8 FTE (full-time equivalent) positions in mental health services delivered through HHS[722]
- 524 FTE positions in AOD services[723] delivered through HHSs.[724]

Queensland Health advised:

> The lived experience workforce accounted for two per cent of all the FTE positions. Although this workforce remains small, there are 12.9 Consumer Worker FTE positions and 4.4 Carer Worker FTE positions per 1,000 direct care FTE in Queensland, well above the national average of 7.0 and 2.5 respectively.[725]

7.2 Workforce shortages

The committee heard of significant workforce shortages across Queensland's mental health and AOD sector, including clinical, non-clinical and allied health workers. Stakeholders also identified the lived experience (peer) workforce as being underutilised despite the skills and experience the cohort offers.[726]

These shortages are exacerbated by the ongoing impacts of the COVID-19 pandemic and the projected loss in the workforce. For example, the Brisbane South PHN advised:

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719 Public hearing transcript, Brisbane, 20 January 2022, p 6.

720 Queensland Health, briefing paper, 1 February 2022, pp 9-10.

721 Queensland Health, briefing paper, 1 February 2022, p 18.

722 The staffing breakdown includes: nurses (47%), allied health professionals (21%), administration and support staff (17%).

723 The staffing breakdown includes: nurses (45%), administration staff (15%), social workers (11%), and medical officers (6%).

724 Queensland Health, briefing paper, 1 February 2022, p 18.

725 Queensland Health, briefing paper, 1 February 2022, p 18.

726 See, for example, submissions 48, 150, and 151; public hearing transcripts, Brisbane, 17 February 2022, 10 March 2022, and 20 April 2022.

> ... the increase from 10 to 20 sessions under the Better Access to Mental Health initiative in response to the COVID-19 pandemic has seen private practitioners retain consumers for longer periods of time, effectively reducing availability of practitioners.[727]

With respect to the projected loss in workforce due to retirement, Queensland Health advised:

> Of particular concern is the projected loss due to retirement within 10 years of 2019 of 47 per cent of Mental Health and 57 per cent of AOD registered nurses and 37 per cent of enrolled nurses, with this impact increased in rural and remote areas. The five-year projected losses of 20 per cent of MH and 26 per cent of AOD registered nurses require urgent recruitment of entry level graduates to maintain supply of this skilled workforce. Other workstreams predicted to exit the industry in significant numbers by 2029 include 38 per cent of psychiatrists, 37 per cent of psychologists, and 33 per cent of occupational therapists.[728]

7.2.1 Clinical shortages

The committee heard from stakeholders of significant gaps in the clinical mental health and AOD workforce, particularly for psychiatrists, psychologists, GPs, mental health nurses and addiction medicine specialists and addiction psychiatrists.[729]

7.2.1.1 Psychiatrists and psychologists

The RACGP Queensland Branch advised that private psychiatrists and psychologists often have long waitlists, and many patients are unable to afford the private out-of-pocket expense.[730]

The RACGP Queensland Branch added that:

> In certain circumstances, general practice is the only point of care for people who require mental health services, especially for low socio-economic groups, those living in rural and remote areas, and people with dual diagnosis—for example, a mental health condition in combination with substance use for chronic pain.[731]

The APS advised that recent estimates are that Australia has only 35% of the required psychology workforce. The APS added:

> This is reflected in findings of a survey of our members earlier this year, which found that 88 per cent of psychologists have seen an increase in demand for services, that clients are often waiting three months to see a psychologist and some more than six months, and that one in three psychologists are unable to see new clients.[732]

7.2.1.2 General practitioners

The RACGP Queensland Branch advised:

> There is an incredibly strong demand for mental health services, including private mental health services provided at a cost to consumers, and we have seen demand outstrip supply even in the private sector. We need to invest in the training pipeline for GPs, in budding psychiatrists, psychologists and other potential mental healthcare providers into this sector—more importantly, into our regional centres.[733]

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727 Submission 87, p 12.

728 Submission 150, p 21; p 60.

729 See, for example, submissions 87 and 150; Public hearing transcript, Brisbane, 17 February 2022, p 2.

730 Public hearing transcript, Brisbane, 17 February 2022, p 2.

731 Public hearing transcript, Brisbane, 17 February 2022, p 2.

732 Australian Psychological Society, public hearing transcript, Brisbane, 10 March 2022, p 36.

733 Public hearing transcript, Brisbane, 17 February 2022, p 10.

The South Burnett CTC Inc. described the shortage of GPs in the South Burnett region:

> I believe we currently have something like 25 GPs in the various practices in the South Burnett. I am not entirely certain of that number, but something in that region. They are servicing 35,000 people, roughly speaking, and every single clinic that I know of is not taking on new patients. Fundamentally people have to die to create a vacancy on a GP list.
>
> A lot of the GPs are also here usually for fairly short spells. The established doctors have younger junior staff with them who stay for a year or two at most and that, of course, for mental health patients is then a major issue, especially for our young ones who are absolutely fed up with having to repeat their story time and time and time again and nothing happens at the end of it.[734]

7.2.1.3 Mental health nurses

The committee heard of a reported decline in the number of mental health nurses in Queensland. The QNMU advised:

> Mental health nurses are the largest occupational group within the mental health workforce and also make up the bulk of hospital based mental health care and prison mental health services. There are approximately 4,600 mental health nurses working in Queensland today.[735]

7.2.1.4 AOD workforce

QNADA explained that while only a relatively small proportion of people who use alcohol and other drugs experience problematic use, there is insufficient supply of specialist alcohol and other drugs treatment and harm reduction services to meet demand.[736]

Queensland Health advised there is a shortage of addiction medicine specialists and addiction psychiatrists.[737]

7.2.2 Allied health workforce shortages

Queensland Health advised that allied health professionals are under-represented in HHS mental health services, stating:

> The lower numbers of allied health staff employed in HHS MH services potentially impacts on the outcomes. While the majority of QH employed psychologists work in MHAOD services, the number of psychologists is still less than the recommended targets in the NMHPF within many services.
>
> Of the remaining QH allied health workforce within HHS MHAOD services:
>
> - 20 per cent (246) are social workers
> - 4 per cent (20.5) speech therapists and audiologists
> - 3.5 per cent (20) dietitians
> - 20 per cent (7.5) exercise physiologists
> - less than 1 per cent (9.3) pharmacists.[738]

Queensland Health added:

> Apart from social workers, the remaining allied health staff are also maldistributed across HHS MHAOD services. The lack of dedicated allied health staff constrains the capacity of services to deliver clinical

734 Public hearing transcript, Kingaroy, 20 April 2022, p 5.

735 Public hearing transcript, Brisbane, 10 March 2022, p 40.

736 Submission 48, p 17.

737 Public hearing transcript, Brisbane, 20 January 2022, p 7.

738 Submission 150, p 60.

> interventions to reduce the significant co-morbidities associated with long term mental health illness and treatment modalities.[739]

7.3 Barriers to attracting and retaining a skilled mental health and AOD workforce

Attracting and retaining skilled staff was a key theme raised by stakeholders in relation to workforce shortages, particularly in rural, regional and remote parts of Queensland.[740]

The committee heard of a number of barriers impacting the provision of mental health and AOD treatment, care and support.[741] For example:

- stigma associated with mental health and AOD careers
- exacerbation of workforce pressures by attrition due to an ageing and/or fatigued workforce
- insufficiently developed and articulated pipelines for new entry workers, including vocational and tertiary training, mentoring and supervision, and recruitment pathways
- shortfalls identified across mental health and AOD specialised work streams and settings in a context of overarching shortages of skilled workers across the sector
- inequitable workforce distribution across geography, culture, service type and setting
- cultural safety needs of higher representation of Aboriginal and Torres Strait Islander and CALD groups presenting with severe and persistent issues
- ensuring an appropriate mix of clinical and non-clinical multidisciplinary team members and optimising scope of practice of multidisciplinary team members.[742]

The APS described the barriers to attracting psychologists to the public mental health system:

> … the challenging working conditions facing psychologists in the public system, and limited career pathways, has led to a movement of the workforce out of the public system into private practice. In private settings, psychologists are better remunerated and are typically able to choose their own hours which helps them to manage burnout and work-life balance.[743]

With respect to the AOD workforce, QNADA advised that:

> … alcohol and other drug services attract around a tenth of the funding of mental health services. Forty one per cent of full time alcohol and other drug workers earn less than the average Australian income. It's difficult to attract and retain qualified professionals to a sector that is so chronically underfunded, which makes it difficult to improve specialisation.[744]

739 Submission 150, p 60.

740 See, for example, submissions 48, 63, 87, 150, and 151.

741 See, for example, submissions 48, 63, 87, 150, and 151.

742 Queensland Health, submission 150, p 59.

743 Submission 63, p 6.

744 Submission 48, p 21. NB: in-text referencing removed. Refer to original source for more information.

7.3.1 Stigma associated with mental health services

The National Mental Health Workforce Taskforce noted that there is widespread negative perceptions of working in mental health.[745]

The committee heard that working in mental healthcare is associated with stigma.[746] For example, Dr Stephen King, Productivity Commissioner, explained that during the course of the Productivity Commission's inquiry into mental health, it heard:

> … examples of young nursing graduates who are thinking of going on and doing a mental health specialisation essentially being talked out of it because of the view that working in mental health is not quite at the same level as working in physical health care. I think we need to get over that stigma as part of our workforce planning. If we have a workforce that is stigmatising mental health issues, we are in some trouble.[747]

According to the National Mental Health Workforce Taskforce:

> Addressing the stigma and negative perceptions that people may associate with working in mental health or with specific settings is important to increase the numbers of workers considering careers in mental health.[748]

7.3.2 Competition with the NDIS

Queensland Health noted the expansion of opportunities within the NDIS sector has led to increased competition for workers, especially allied health professionals.[749]

Brisbane South PHN advised that this in part relates to the higher fees paid by the NDIS:

> Fees available to practitioners through the NDIS are higher than those available through the MBS or PHN funded services, which means it's difficult to compete for practitioners in the context of pre-existing shortages.[750]

7.3.3 Limited availability of supervision and placement opportunities

The committee heard of the challenges posed to prospective staff due to the limited availability of mentoring, supervision and placement opportunities for mental health and AOD practitioners in some areas.[751]

In relation to growing the psychology workforce, the APS told the committee:

> Within a short time frame of two to three years, we could easily scale up the number of fully trained psychologists with the right investment in postgraduate university training places with scholarships, sponsored placements, particularly in rural and remote areas, and supporting professional supervision.[752]

The APS advised that psychology students must have access to professional supervision from experienced psychologists, and that there is a lack of placement opportunities in the public sector. The APS explained:

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745 Australian Government Department of Health, National Mental Health Workforce Strategy Taskforce, *National Mental Health Workforce Strategy – Consultation Draft*, August 2021, p 7.

746 Submission 150,

747 Public hearing transcript, Brisbane, 17 February 2022, p 32.

748 Australian Government Department of Health, National Mental Health Workforce Strategy Taskforce, *National Mental Health Workforce Strategy – Consultation Draft*, August 2021, p 9.

749 Queensland Health, submission 150, p 59.

750 Submission 87, p 4.

751 See for example submissions 63, 110, and 140.

752 Public hearing transcript, Brisbane, 10 March 2022, p 37.

> It appears as though the overwhelming demand and case load that everyone is carrying distracts from other very important tasks which, for example, helping train the next generation of psychologists, the overwhelming need for care and the overwhelming patient load. As well, because of that, for anyone who supervises it often appears that they have to do that in their own time as there is not time during their normal duties to undertake that supervision and to do the mandatory training that is required to be a supervisor. They even have to pay for that registration and training themselves.[753]

Committee comment

The committee understands that a shortage of clinical supervision opportunities and limited training and development is creating barriers to developing a skilled mental health and AOD workforce. The committee has also heard that improvements in these areas may assist in attracting and retaining staff.

Recommendation 43 – Support clinical supervision and training and development

The committee recommends that the Queensland Government:

a) explores ways to improve opportunities for:
   i. clinical supervision for mental health and alcohol and other drugs staff
   ii. meaningful training and development opportunities that will upskill staff in providing mental health and alcohol and other drugs related care.

b) identifies opportunities to remove financial and other barriers to practitioners providing clinical supervision and incentivise clinical supervision accreditation to support workforce development.

7.4 Mental health workforce planning and development

In view of workforce shortages and the difficulty in attracting and retaining staff, particularly in rural, regional and remote areas, the committee heard of the need to plan and develop Queensland's mental health and AOD workforce for the future.[754]

The National Mental Health Workforce Strategy – Consultation Draft identifies key mental health workforce development objectives, including ensuring:

- that careers in mental health are seen as attractive
- data drives workforce planning
- the entire mental health workforce is utilised
- the workforce is appropriately skilled, retained and distributed to address population health needs.[755]

To address the shortages of mental health workers across most occupations and sectors, the QMHC advised:

> … a multi-level approach that confronts the structural (e.g., funding cycles, renumeration [sic]), 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.[756]

[753] Public hearing transcript, Brisbane, 10 March 2022, p 38.

[754] Queensland Mental Health Commission, submission 151, p 127.

[755] Queensland Mental Health Commission, submission 151, p 108.

[756] Submission 151, p 127.

Brisbane South PHN advised the committee that workforce planning is a key priority, particularly in meeting workforce needs in remote and very remote areas. Brisbane South PHN added:

> We need to design joint workforce strategies and commit joint resources to implement these. There must also be a focus on a peer or lived experience workforce and longer funding contracts for tenure and security.[757]

Describing the importance of long-term workforce planning, Professor Whiteford stated:

> Given how long it takes to train psychologists, psychiatrists and nurses, we need to start training them now if we need to have them in five, 10 or 15 years time. If you do the modelling for the workforce side of things, you can plan for what you are going to be providing in 10 or 15 years time. That is really important even though you cannot fix the urgent problems now and something will have to be done. You need to make sure those problems do not exist so much in 10 or 15 years time, and the tools to do that are available to governments.[758]

The RANZCP Queensland Branch advised of the need for a central mental health workforce unit:

> We used to have one until 2011. Then it disappeared. … we need to re-establish a mental health workforce unit, of which there needs to be an alcohol and drug section. Again, we cannot let continue what has happened previously, whereby mental health gets the crumbs and the drug and alcohol services get one crumb. It is really to focus on the fact that a central workforce unit is needed and there has to be a significant component of that for the alcohol and drug services.[759]

The committee heard that a highly skilled, competent and sustainable alcohol and other substance use workforce is imperative to effectively prevent and respond to problematic drug and alcohol use and related harms within Queensland.[760]

7.4.1 Salience of mental health career pathways

According to the draft workforce strategy, there is limited awareness of the career opportunities that the mental health sector affords across a wide range of occupations, and this impacts on the number of students enrolling in some of the requisite training programs.[761]

The draft workforce strategy identifies the need to market mental health as an attractive career choice to secondary school students, undergraduates, graduates and the existing health workforce to help build demand for associated training programs, including mental health components within broader programs.[762]

Furthermore:

> Increasing exposure to mental health workplaces in pre-service education and training would help alleviate misconceptions about careers in mental health. The quality and variety of placements is an important factor in breaking down this stigma. Poor quality placements arise when students receive insufficient supervision and support, which can be driven by supervisors having poor supervisory skills or

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757 Public hearing transcript, Brisbane, 17 February 2022, pp 1-2.

758 Public hearing transcript, Brisbane, 17 February 2022, p 31.

759 Public hearing transcript, Brisbane, 12 April 2022, p 65.

760 Royal Australian and New Zealand College of Psychiatrists, submission 140, p 22.

761 This applies to entire programs of study that focus on mental health, and programs of study that include elective units in mental health. It is relevant to occupations that work exclusively in mental health (for example, mental health nurses) and occupations that may work in mental health (such as nurses); Australian Government Department of Health, National Mental Health Workforce Strategy Taskforce, *National Mental Health Workforce Strategy – Consultation Draft*, August 2021, p 7.

762 Australian Government Department of Health, National Mental Health Workforce Strategy Taskforce, *National Mental Health Workforce Strategy – Consultation Draft*, August 2021, p 7.

> insufficient time to devote to planning for and supporting students in their placement or when experiences are confined to acute mental health care settings.[763]

Queensland Health advised of work they are already undertaking to develop the nursing workforce:

> Early career is where we are targeting with our graduates. We had 4,200 graduates this year. Interestingly, 20 to 30 per cent of those graduates actually put mental health as a preference. We are trying to increase that by building the profile of mental health nursing by talking to students and the universities about the opportunities. We are providing videos of positive experiences to try to increase the uptake in those areas.[764]

7.4.1.1 Tertiary education and training

Some stakeholders advised that requisite education and training for certain sectors of the mental health and AOD workforces are not adequately reflected in education pathways in the tertiary system.[765]

A recent workforce report released by the QAMH found that despite the high percentage of community mental health sector staff holding formal qualifications:

> …nearly two thirds of service managers surveyed did not believe that formal qualifications currently on offer adequately train the workforce. They reported concerns that courses did not provide the opportunity to translate theoretical knowledge into practical experience and identified specific workforce knowledge gaps such as trauma-informed care, responding to complex needs, provision of culturally appropriate services, managing risks, establishing professional boundaries, the intricacies of the NDIS, recovery-oriented practice and leadership and management training.[766]

With respect to attracting workers into the AOD sector, QNADA advised that 'very little education happens in tertiary settings around alcohol and other drugs in undergraduate degrees'. QNADA recommended offering majors in undergraduate degrees as a means to 'give people a taste of what the sector is about'.[767]

In terms of the barriers to growing the community AOD workforce, QNADA explained:

> Perhaps the most significant impact is that it holds back the development of our workforce, which we know we have a shortage of, because people leave to go and work in more secure sectors and then we have to start training from the baseline again. There is not a program in this country that produces job-ready graduates for alcohol and drug services. They require further training—not so much psychologists but social workers and nurses. It is a specialised field.[768]

Queensland Health acknowledged the need to work in partnership with universities to skill the nursing and allied health workforce:

> It is around how we partner with the universities to ensure the training that is provided is actually developing the skills and how you then provide the support with regard to what you are learning at the universities and then applying it to practise within hospitals. We need to have that partnership model,

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763 Australian Government Department of Health, National Mental Health Workforce Strategy Taskforce, *National Mental Health Workforce Strategy – Consultation Draft*, August 2021, p 7.

764 Public briefing transcript, Brisbane, 20 January 2022, p 6.

765 See, for example, submissions 115 and 119.

766 Submission 119, p 33.

767 Public hearing transcript, Brisbane, 16 February 2022, p 8.

768 Public hearing transcript, Brisbane, 16 February 2022, p 6.

> being able to work together. What you learn in a textbook is not necessarily the same as what you see when you are out here on the ground.[769]

Productivity Commissioner, Dr Stephen King explained that the decline in numbers of mental health nurses is a result of a shift in curriculum whereby mental health nursing has, 'gone from being a dedicated undergraduate degree to being a bit of an add-on at the postgraduate level'.[770]

The ACMHN submitted that undergraduate nursing or midwifery degrees should be bolstered with more mental health content that includes models of suicide prevention and relevant clinical placement.

ACMHN added that mental health should not be a separate curriculum but be included in the nursing or midwifery undergraduate degrees to build a flexible, holistic and integrated mental health workforce with the capacity to address mental health concerns and suicide prevention across all health services.[771]

QFCC Youth Advocate, Ms Sholl, highlighted the need to, 'invest in the future of mental health by investing in students through increased capacity for university places for mental health related disciplines and increased support for postgraduate students seeking to become mental health specialists'.[772]

The QMHC advised that expanded relationships with education providers to align supply with future demand is required. The QMHC submitted:

> 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.[773]

Committee comment

The committee understands that the former Mental Health Workforce Planning and Development Branch operating within the Department of Health was previously responsible for Queensland Health's mental health and AOD workforce planning.

The committee notes the *National Mental Health Workforce Strategy – Consultation Draft* developed by the National Mental Health Workforce Strategy team, and the committee supports the development of Queensland's mental health and AOD workforce in line with the next iteration of the *National Mental Health Workforce Strategy* once it is finalised.

The committee has heard of the limited awareness of mental health and AOD career pathways which impacts on the number of students enrolling in mental health and AOD related training programs. The *National Mental Health Workforce Strategy – Consultation Draft* identified the need to market mental health as an attractive career choice to secondary school students, undergraduates and graduates. It is the committee's view that long-term mental health and AOD workforce planning requires engagement with the secondary and tertiary education sectors.

769 Public hearing transcript, Brisbane, 29 April 2022, p 9.

770 Public hearing transcript, Brisbane, 17 February 2022, p 32.

771 Submission 115, p 6.

772 Published in camera transcript, Brisbane, 11 February 2022, p 2.

773 Submission 151, p 129.

Recommendation 44 – Mental health and alcohol and other drugs workforce planning and development

The committee recommends the Queensland Government re-establishes the Mental Health Workforce Planning and Development Branch within the Department of Health and that the branch engages with the secondary and tertiary education sectors in developing the mental and alcohol and other drugs workforce.

7.4.2 Regional, rural and remote services

The Productivity Commission found that access to mental health professionals, especially for specialist care, falls dramatically outside of major capital cities.[159]

Numerous stakeholders highlighted the difficulty of attracting and retaining staff in rural and regional parts of Queensland.[774]

The Torres and Cairns HHS raised the impact of the lack of accommodation, stating that despite the need to build its workforce, 'there just is not housing out there to able to house staff'.[775]

The RACGP Queensland Branch noted:

> As long as there is statewide demand for services, rural, remote and regional centres areas will continue to struggle to attract and retain a mental health workforce as city based demand attracts providers with better remuneration and lifestyle considerations. To solve the rural workforce shortage, it needs to be done in tandem with a workforce audit solution for the state, not in isolation. We need strategies and funding in place to improve and protect the psychological wellbeing of our workforce.[776]

Lived Experience Australia recommended the provision of incentives to recruit mental health staff (psychiatrists, psychologists, mental health nurses, allied health therapists and lived experienced peer workers) to rural areas, as 'the costs of living and accommodation, social isolation and lack of peer support deters workers from moving to rural areas'.[777]

Stakeholders described some of the challenges facing people who choose to work in rural and regional towns. For example, Professor Brett Emmerson AM, chair of the RANZCP Queensland Branch, explained:

> One of the problems for psychiatry … is the fact that when you are in even large centres like Cairns people know a lot about you. As a health professional, it is much easier to hide in Brisbane. When I was in Cairns everybody knew where my wife shopped. If you have dinner somewhere, people know you. Sometimes as a psychiatrist you have to make decisions that people do not particularly like. Trying to remain protected is a challenge. That is something that I do not know how to get around.[778]

Queensland Health staff situated in the Torres and Cape HHS advised of the lack of incentives available for the allied health and non-clinical workforce:

> We are able to attract some nurses with some incentives with Remote Area Nursing Incentive Packages and some housing sites, but the other multidisciplinary team—allied health, health workers et cetera—do not have the same support. That is identified in the industrial awards. In terms of our health worker recruitment, that is again challenging the pathways for our Aboriginal and Torres Strait Islander mental

774 See, for example, submissions 71, 83, and 93.

775 Public hearing transcript, Brisbane, 29 April 2022, p 8.

776 Public hearing transcript, Brisbane, 17 February 2022, p 10.

777 Lived Experience Australia, submission 12, p 4.

778 Public hearing transcript, Brisbane, 12 April 2022, p 64.

> health workers. That is something that we are really keen to make more robust so we have the appropriate skill sets for the staff.[779]

The QMHC recommended 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 remuneration, employment arrangements and practice support
- support online professional development opportunities and communities of practice.[780]

Recommendation 45 – Incentivise rural and regional Queensland Health jobs in mental health and alcohol and other drugs

The committee recommends that the Queensland Government:

a) reviews employee entitlements for clinical and non-clinical mental health and alcohol and other drugs roles to incentivise work in regional, rural and remote communities, including housing entitlements.

b) investigates and implements additional strategies to attract and retain skilled mental health and alcohol and other drugs practitioners to regional, rural and remote parts of Queensland, and considers safe working conditions for people working in these locations.

c) that formal certification of advanced credentialed practice for Mental Health and/or Addiction Medicine for Rural Generalists be formally recognised by Queensland Health.

7.4.3 Scope of practice

The committee heard from a range of stakeholders in the mental health and AOD workforce about issues preventing them from working to their full scope of practice, which impacts employee attraction and retention, and workforce development.[781]

A Queensland Health employee described the value for staff when able to work to their full scope of practice:

> In my experience in workforce capacity, that is generally what most staff are wanting for satisfaction in their role—that is, to have the ability to work to the highest level of your scope of practice and to feel you are contributing to better outcomes for consumers.[782]

7.4.3.1 Impact of case management model in public mental health services

Queensland Health described the challenges around scope of practice due to its use of a case management model. Queensland Health added:

> We are having difficulty attracting those workforces that I talked about into mental health careers because they are not seen as attractive careers because the practitioners are not able to work to their

779 Public hearing transcript, Brisbane, 29 April 2022, pp 7-8.

780 Submission 151, p 97.

781 See, for example, submissions 38, 150, and 115.

782 Public hearing transcript, Brisbane, 29 April 2022, p 9.

> full scope of practice. Because of the model that we have, there is also no career progression or pathway for clinical expertise. They tend to end up being team leader or team manager roles.[783]

In relation to clinicians working to their full scope of practice, Queensland Health further explained:

> For everybody's benefit, the scale goes from HP3 to HP8. The majority of our workforce obviously sit in the HP3 or HP4 area. It provides the opportunity to establish senior clinical as well as senior management positions at the HP5, 6 and 7 levels. What we see is some more senior level clinical positions in more of our physical health services. We have a well-qualified and senior HP5 and 6 clinical workforce in physiotherapy and orthopaedics for example. Because of our services and our service model within mental health what we historically see is that once we get to the HP5/6 level they are managerial roles. …there is a real opportunity to create the space for those senior roles to be able to continue to work clinically.[784]

7.4.3.2 Underutilised workforces

Stakeholders from various practice areas, including nursing, occupational therapy and counselling, expressed that their workforces are underutilised in mental health service provision. Stakeholders have suggested working to full scope of practice might alleviate some of the workforce pressures being experienced in Queensland.[785]

Nurse practitioners

The ACMHN advocated for nurse practitioners to be utilised to their full scope of practice.[786] According to the ACNP, a nurse practitioner is:

> …a Registered Nurse with the experience, expertise and authority to diagnose and treat people of all ages with a variety of acute or chronic health conditions. NPs [nurse practitioners] have completed additional university study at Master's degree level and are the most senior and independent clinical nurses in our health care system.[787]

The ACMHN advised it supports nurse practitioners working in diverse areas of mental health, as they hold numerous additional qualifications and often have decades of mental health nursing experience.[788]

ACMHN added that, like generalist nursing, mental health practitioners have undertaken academic and regulatory assessment to achieve endorsement via national regulation, which approves advanced scope of practice.[789]

Occupational therapists

OT Australia advised that the full scope and value of occupational therapy is currently underutilised and is too often inaccessible to clients in the primary healthcare setting. According to OT Australia, this results in an undue burden on other health services and a failure to utilise all available resources in an already understaffed field.[790]

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783 Public hearing transcript, Brisbane, 20 January 2022, p 12.

784 Public hearing transcript, Brisbane, 20 January 2022, p 13.

785 See, for example, submissions 38, 51, and 115.

786 Submission 115, p 7.

787 Australian College of Nurse Practitioners, *What is a nurse practitioner?*, https://www.acnp.org.au/aboutnursepractitioners.

788 Submission 115, p 7.

789 Submission 115, p 7.

790 Submission 38, p 9.

Counsellors

The Australian Counselling Association (ACA) submitted that counsellors are an underutilised and highly qualified workforce that could alleviate some of the strain on Queensland's health system, evidenced by the long wait times for psychologists and psychiatrists.[791]

ACA advised that there are 2,200 ACA registered counsellors based in Queensland, 30% of which are in regional and rural areas, and could be utilised in hospitals where it is considered that burnout is currently a major issue. The ACA explained:

> Registered councillors [sic] are better placed than psychologists and social workers in this space to provide the type of frontline counselling required, with no diagnosis, early intervention, with potentially ongoing referrals—so triage counselling if you wish.[792]

The ACA noted that counsellors are currently employed in Queensland's private school system and recommended the introduction of registered counsellors into the public school system.[793]

Ms Hudson commented on the benefit of being able to access a team of counsellors in her own school:

> The great thing that worked with that was that kids who could not get access to mental health services outside of school were able to go and see them during their lunchbreaks or maybe when they had a study period to talk about generalised things like maybe you are stressed for an exam or maybe it is a major family breakdown. They then had access outside of this to other mental health services that could then direct them to specialists and get them the further help that they needed, taking steps and following the procedures to look after young people.[794]

7.4.3.3 Medicare Benefit Scheme barriers to full scope practice

Some stakeholders described issues relating to the MBS as potentially limiting their ability to work to their full scope of practice.[795]

For example, the ACA told the committee that the MBS mandate incentivises GPs to refer patients to a psychologist as opposed to a counsellor:

> When you look at it in the actual therapeutic setting, it depends whether or not you go through the MBS. The MBS mandate is based on the old Westminster system of CBT or cognitive behaviour therapy. When you go to a GP, the GP is financially incentivised to give the referral to a psychologist, as I am sure you are all aware. GPs can refer to counsellors but they do not for obvious reasons. When you go through that system, that psychologist is mandated by Ahpra and MBS not only to do all the reporting but also to stick to certain therapies whereas a councillor [sic] may use different therapies. [796]

Queensland Health also advised of the barriers facing the allied health workforce:

> …in terms of some of the funding arrangements under the MBS for allied health interventions for mental health patients we are reliant on general practitioners for the referral to get access to the Better Access program number of sessions, but we are also then reliant on that general practitioner to understand the scope of practice of the different allied health professions that are able to deliver those services. We could see much greater use of our occupational therapy and social work workforces through MBS items if we removed the tiering system and we were able to promote better access to those workforces.[797]

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791 Submission 51, p 5.

792 Public hearing transcript, Brisbane, 12 April 2022, p 26.

793 Public hearing transcript, Brisbane, 12 April 2022, pp 27-28.

794 Published in camera hearing transcript, Brisbane, 11 February 2022, p 6.

795 See, for example, submissions 51, 110, and 120.

796 Public hearing transcript, Brisbane, 12 April 2022, pp 27-28.

797 Public hearing transcript, Brisbane, 20 January 2022, p 12.

AAPi described the need to broaden MBS 'rebatable' sessions to psychologists to include prevention and early intervention, not just mental illness.[798]

AAPi advised that treatment of families and couples is significantly underfunded and recommended the committee consider funding for couples counselling, family-based therapy work and screenings for early intervention. AAPi explained:

> This is extremely important to address, as attachment-based issues (those found in couples and families) cause significant lifelong distress for children and other family members. When these issues are addressed earlier through the provision of family-focused therapies or couple therapy, it reduces the severe trauma and distress experienced and felt by children and family members across their lifespan. Many issues seen in children are also best dealt with by implementing family-based therapies as are some disorder types such as eating disorders. Similarly, when families are supported through distressing events such as separation and divorce, then the mental health of children is best protected.[799]

The ACNP advised that despite nurse practitioner MBS items allowing for unlimited number of consultations, unrestricted by Mental Health Care Plans, 'nurse practitioner MBS items provide much lower MBS rebates when compared to MBS items for other mental health professionals'.

ACNP suggested that:

> …the Queensland Government might consider supporting alternate funding strategies to address this issue, which otherwise limits the capacity of nurse practitioners to provide care to low-income clients outside the public hospital system.[800]

Committee comment

Stakeholders reported that nurses and midwives are pivotal to the delivery of mental healthcare in Queensland. The committee heard evidence of the significant projected workforce shortages in mental health and AOD nursing and midwifery.

The committee also notes section 6.3.3.4 of this report, which describes the positive impact nurses and midwives have in preventing postnatal depression in perinatal and infant mental health services.

The committee also heard of the shortage in allied health professionals and the need to leverage this workforce to respond to service gaps.

To address current and projected workforce shortages, the committee considers that the Queensland Government should fund scholarships for nurses, midwives, medical officers and allied health professionals, such as occupational therapists and counsellors, to pursue mental health qualifications.

Recommendation 46 – Support scholarships to pursue mental health qualifications

The committee recommends the Queensland Government funds scholarships for nurses, midwives, medical officers and allied health professionals, such as occupational therapists and counsellors, to pursue mental health and alcohol and other drugs qualifications.

Committee comment

The committee heard of the impact of Queensland Health's case management model on the mental health workforce. It is the committee's view there is a need to review the operation of the 8-level health practitioner structure to ensure clinicians are attracted to and retained in clinical mental health settings, particularly in senior clinical roles. This will not only create a defined clinical career pathway

798 Submission 110, p 8.

799 Submission 110, p 9.

800 Submission 120, p 4.

for mental health and AOD care, but will ensure Queenslanders are provided clinical mental healthcare that is responsive to their needs.

Stakeholders have highlighted the need for the mental health and AOD workforce to work to its full scope of practice to alleviate workforce and service delivery pressures, including leveraging underutilised groups such as counsellors and other allied health professionals.

The committee also understands that broadening the MBS rebates across the mental health and AOD workforce would contribute to the uptake of mental health services in underutilised sectors and provide a wider range of available subsidised treatments. For these reasons, the committee has made the following recommendations.

Recommendation 47 – Review health practitioner structure

The committee recommends the Queensland Government reviews how the health practitioner structure operates within Queensland Health, including whether there are sufficient clinical roles across the 8-level structure to attract and retain clinical staff.

Recommendation 48 – Utilise mental health workforce to full scope of practice

The committee recommends the Queensland Government, in partnership with Hospital and Health Services, non-government organisations and private sector employers, supports employees in the mental health and alcohol and other drugs workforce to work to their full scope of practice across the continuum of care settings.

Recommendation 49 – Leverage the counselling workforce

The committee recommends the Queensland Government, in partnership with the Hospital and Health services, investigates how to leverage the counselling workforce in community-based primary healthcare settings, hospitals, private and state-funded schools, and in crisis support spaces where not already employed.

Recommendation 50 – Expand Medicare Benefit Scheme rebates

The committee recommends the Queensland Government collaborates with the Australian Government to ensure Medicare rebates are available to customers for all mental health and alcohol and other drugs practitioner services.

7.4.4 Leveraging the allied health workforce

The Productivity Commission found that 'low-intensity' services may better serve just under half of people accessing mental health medication or psychologists, or both.[801] The committee heard there is a role for the allied health and non-clinical workforce to improve availability of low intensity support services.

For example, headspace explained:

> …we believe that it is not necessary for highly qualified clinicians to deliver low intensity support services, and that these could be delivered by a trained community workforce, especially in services that could provide supportive coaching by those with lived experience, including the use of digital platforms.[802]

In relation to the challenges facing the public mental health service in Queensland, the Chief Allied Health Officer explained:

> There is greater scope for us to access not just counsellors but access bachelor level qualified counsellors. We could look at what sorts of patients they would be able to assist in seeing under a clinical governance

[801] Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 526.

[802] headspace, submission 66, p. 27.

> arrangement with a qualified mental health practitioner. There are number of other allied health workforces that could make a significant contribution, particularly around some of the cognitive behavioural therapy interventions. I am thinking about speech pathologists, psychologists, exercise physiologists and physiotherapists who can assist with some of those behavioural therapies. There is an untapped workforce for mental health services from the allied health professions and we need to look at how we can best leverage the skills and expertise that they can bring.[803]

OT Australia advised:

> In the undergraduate courses OTs do get trained in mental health as well as physiology and anatomy. We have that fundamental knowledge in mental health. Then when an OT works in mental health they learn on the job or they do further training and studies. A lot of the mental health OTs would be trained in a number of therapeutic approaches—CBT or other types of therapeutic approaches—with the lens of an OT coming from a holistic view of a person, from a recovery focus perspective, and also looking at what is meaningful for the person.[804]

With respect to developing the non-clinical workforce, the QAMH advised a lot of reform has already occurred around what they term 'the big five: doctors, nurses, psychologists, OTs and social workers'.[805] QAMH added:

> But we know that the mental health workforce is made up of more than that. It is made up of counsellors, telephone counsellors, creative art therapists, community and psychosocial support workers, peer workers, personal care assistants, recovery coaches, alcohol and other drug workers, social workers, OTs, psychotherapists, managers, volunteers—the list goes on. …we need real investment to create career pathways for people into the community sector. …There is a piece of work that could be done around that and that might help some of the skills shortages we particularly see in regional and remote parts of Queensland.[806]

In relation to GP referrals to allied health services, OT Australia advised:

> A coordinated system where GPs fully utilise the allied health workforce would help remove barriers for clients to access mental health services. Currently, by inefficiently funnelling [sic] allied health through an already overstretched GP workforce, an unnecessary hurdle is added to accessing multidisciplinary care. In addition to referrals from GPs, access to mental health allied health professionals should be available and encouraged through other primary health programs.[807]

7.4.4.1 Integrating physical and mental health workforces

The committee heard of the need to better integrate physical and mental health services, including providing access to dietitians and exercise physiologists in the provision of mental healthcare.[808]

Exercise & Sports Science Australia advised that there is a lack of access to physical health therapies for people at risk of and experiencing mental ill-health and that the importance of including exercise interventions to improving physical health outcomes for people living with mental illness has been established in clinical research.[809]

Dietitians Australia explained:

> Access to healthy food and nutrition care are significant factors in the prevention and treatment of mental illness and co-occurring physical illnesses. Improved ability to seek nutrition and dietetic services,

803 Public hearing transcript, Brisbane, 20 January 2022, p 12.

804 Public hearing transcript, Brisbane, 29 April 2022, p 12.

805 Public hearing transcript, Brisbane, 10 March 2022, p 24.

806 Public hearing transcript, Brisbane, 10 March 2022, p 24.

807 Submission 38, p 9.

808 See, for example, submissions 3, 49 and 52.

809 Submission 52, p 6.

> supported by government reforms, funding and coordinated healthcare will enable people with mental illness to improve their health and increase their social and economic participation.[810]

Committee comment

Research has evidenced the strong association between mental and physical health. The committee notes the complex and bidirectional nature of comorbid mental and physical health conditions.

As noted in section 5.3, research suggests that people experiencing mental ill-health are more likely to develop a physical illness due to factors including stigma, lack of health service integration, and a lack of clarity about who is responsible for physical health monitoring in people living with a mental illness. For these reasons, the committee supports the integration of dietitians and exercise physiologists within the mental health workforce to provide holistic physical and mental healthcare.

Recommendation 51 – Treat mental and physical health comorbidities

The committee recommends that Queensland Government integrates dietitians and exercise physiologists within the mental health workforce to provide more holistic care to people experiencing mental and physical health comorbidities.

Recommendation 52 – Leverage the allied health workforce

The committee recommends the Queensland Government increases the role of allied health professionals in primary health care settings with the process receiving input from general practitioners and people with lived experience.

7.4.4.2 Mental health pharmacists

The committee heard of the 'increasingly vital role' of mental health pharmacists.[811]

According to the Pharmaceutical Society of Australia Ltd, community pharmacists have played a key role in managing patients' health concerns by using their clinical training to 'assess then treat or refer' based on the patient's needs. This contribution provides timely access to care and reduces the burden on general practice and hospitals.[812]

The Pharmaceutical Society of Australia Ltd suggests that the role pharmacists play in supporting patients to manage mental health issues is underpinned by the accessibility and availability of pharmacists. Many pharmacists meet and talk to people with mental health issues on a regular basis and are well placed to help them and refer them to other health professionals when appropriate.[813]

The Pharmacy Guild of Australia (PGA) advised that community pharmacists have a key role to play in promotional activities to increase awareness of mental health issues and suicide (or self-harm) risk. Community pharmacists can help to raise awareness of such health issues by providing awareness materials such as promotional leaflets or fact sheets. According to the PGA:

> Distribution of information materials through community pharmacies provides patients with easy access to important mental health and suicide (or self-harm) prevention information with the opportunity to

[810] Submission 49, p 3.

[811] Public hearing transcript, Brisbane, 12 April 2022, p 59.

[812] Pharmaceutical Society of Australia Ltd., *Pharmacists in 2023: For patients, for our profession, for Australia's health system*, February 2019, p 40.

[813] Kardachi, Grant, National President, Pharmaceutical Society of Australia published by Mental Health Australia, *Pharmacists' role in mental health*, 12 June 2014; see https://mhaustralia.org/general/pharmacists-role-mental-health.

> seek further advice from a highly trained health professional. Community pharmacy can also provide valuable public awareness services such as provision of information on services available to at-risk people and family members.[814]

The PGA also advised that the community pharmacy workforce has long been involved in reducing AOD-related harm. The PGA advised of the following AOD-related activities commonly undertaken by community pharmacists:

- needle, syringe and other injecting equipment supply
- safe collection and disposal of used needles and syringes
- opioid dependence treatment programs
- benzodiazepine reduction programs with supervised doses
- staged supply programs
- recording of the sale of pseudoephedrine-based products through the Project STOP online real-time monitoring system
- smoking cessation advice and treatment
- supply of naloxone as a Pharmacist Only medicine, including as part of a Take-Home Naloxone Pilot
- reviewing real-time prescription monitoring systems, where available, to aid in harm minimisation (QScript in Queensland)
- interprofessional collaboration activities such as referral of drug users to appropriate treatment or agencies, usually through their GP
- providing information and educational resources such as Information on drug-related conditions (hepatitis C, HIV/AIDS etc) to prevent overdose deaths and reduction of infections.[815]

Recommendation 53 – Role of pharmacists in mental health and alcohol and other drugs workforce

The committee recommends the Queensland Government investigates the role of pharmacists in the mental health and alcohol and other drugs workforce.

7.4.5 Lived experience (peer) workforce

A number of stakeholders raised the importance of developing and expanding the lived experience (peer) workforce to support Queensland's mental health and AOD service provision.[816]

The committee notes that the lived experience workforce is made up of a wide range of roles, including:

> …carer consultants; experts by experience; peer support workers; carer peer workers; cultural peer support workers; specialist peer workers; and various designated lived experience roles in executive

814 The Pharmacy Guild of Australia, correspondence, 19 May 2022, pp 1-2.

815 The Pharmacy Guild of Australia, correspondence, 19 May 2022, p 7.

816 See, for example, submissions 48, 66, 73, 140, 150 and 151.

> governance, board and committee representation, education, training, research, consultancy, policy design and systemic advocacy across a variety of service settings.[817]

The National Mental Health Commission's *National Lived Experience (Peer) Workforce Development Guidelines* (National Guidelines) provide that lived experience work has distinct values, principles, and theories that define lived experience work and the way it is practiced. [818]

The Productivity Commission defines 'peer workers' as:

> …people with a lived experience of mental ill-health (or carers of people with mental ill-health) who provide emotional and social support to others with a common experience. Having experienced mental illness and recovery first-hand, peer workers exemplify the possibility of recovery to people experiencing mental illness, and are able to inspire hope, optimism and empowerment through genuine examples of overcoming adversity.[819]

Queensland Health highlighted the distinction between peer and carer peer workforces:

> The lived experience (peer) workforce consists of two distinct categories - 'peer worker' and 'carer peer worker'. The National Lived Experience (Peer) Workforce Development Guidelines (National Guidelines) describes a peer worker as someone who has a 'personal experience of mental health challenges, service use, period of healing/personal recovery'. A carer peer worker is described as someone who has an 'experience of supporting someone through mental health challenges, service use, periods of healing/personal recovery'.[820]

Mental Health Lived Experience Peak Queensland noted people with lived experience have a role not only in service provision, but in mental health policy development:

> Involving people with lived experience in the defining of the problem as well as considering possible solutions will create different outcomes. For this to work there needs to be a genuine equalisation of power between those with lived experience and those in the professions and bureaucracies in that process.[821]

Acknowledging the unique role of peer workers, the RANZCP Queensland Branch stated:

> Peer mental health workers can perform a role that I cannot. You will see peer workers sit down with people who are agitated and they are able to tell them, 'I was like you three or four years ago. This is what I've done, this is what I've achieved and these are strategies you might consider.' The peer workforce is very underfunded and undervalued.[822]

The committee notes that both the National Guidelines and the *Queensland Framework for the Development of the Mental Health Lived Experience Workforce* (the Queensland Lived Experience Framework) have been co-designed with the expertise of people with lived experience of mental ill-health.[823]

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817 Queensland Mental Health Commission, *Queensland Framework for the Development of the Mental Health Lived Experience Workforce,* 2019, p 8.

818 Australian Government, National Mental Health Commission, *Lived Experience (Peer) Workforce Development Guidelines*, p 4.

819 Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 724; in-text citations removed.

820 Submission 150, p 63.

821 Mental Health Lived Experience Peak Queensland, submission 133, p 16.

822 Public hearing transcript, Brisbane, 12 April 2022, 59.

823 Australian Government, National Mental Health Commission, *Lived Experience (Peer) Workforce Development Guidelines*, p 2; Queensland Mental Health Commission, *Queensland Framework for the Development of the Mental Health Lived Experience Workforce*, 2019, p 3.

7.4.5.1 Regulation of industry and workforce development guidelines

The rapid expansion of the lived experience (peer) workforce has given rise to numerous challenges. At the national level, it has been noted that the expansion of the role in Australia appears ad hoc and lacks structured workforce development.[824]

The Queensland Lived Experience Workforce Network submitted:

> The Lived Experience Workforce (LEW) is significantly expanding across Mental Health, Alcohol & Other Drug (MHAOD) and the Suicide Prevention (SP) services in Queensland. As the sector moves away from a deficit based framework and moves towards a Social and Emotional Wellbeing agenda, the value the LEW contributes - towards organisations providing services and to the people and communities who receives services - is substantial. …
>
> However, currently this remains an unregulated workforce with few formalised structures in place to support safety and quality. With no oversight of professional bodies, the success and sustainability of the LEW in the health system is disadvantaged.[825]

Recently released by the QMHC, the Queensland Lived Experience Framework intends to assist and guide organisations across sectors and along all stages of lived experience workforce development. It is anticipated the framework will provide a guiding document for widespread use in the public, non-government and private sectors to inform development of the lived experience workforce and improve lived experience employment and collaboration within mental health settings.[826]

The framework focuses on the following key areas:

- understanding and defining lived experience roles
- organisational commitment
- workplace culture
- diversity and inclusion
- human resources policies and practices
- professional development and training
- ongoing development.[827]

In relation to the framework, Peer Participation in Mental Health Services Network advised the committee, 'what we are seeing is investment in writing these documents, but we are not seeing the investment into actually implementing them'.[828]

The Queensland Lived Experience Workforce Network submitted that there a number of gaps that must be addressed to support the growth of the lived experience workforce, including:

- strategy and investment to implement and progress the Queensland Lived Experience Framework

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824 Queensland Health, submission 150, p 64.

825 Submission 80, p 1.

826 Queensland Mental Health Commission, briefing paper, 20 January 2022, p 30; Queensland Mental Health Commission, *Queensland Framework for the Development of the Mental Health Lived Experience Workforce,* 2019, p 1.

827 Queensland Mental Health Commission, *Queensland Framework for the Development of the Mental Health Lived Experience Workforce,* 2019, p 9.

828 Public hearing transcript, Brisbane, 10 March 2022, p 15.

- quality assurance of lived experience professional training and development (including certificate IV in Mental Health Peer Work)
- prioritising the implementation of the National Lived Experience Guidelines and Standards.[829]

Queensland Health advised that the MHAOD Branch recognises the value of the lived experience (peer) workforce and the need to include the voice of their leaders in decision making. According to Queensland Health, its Lived Experience Workforce Leadership Group provides leadership and expert advice from a lived experience perspective and promotes the mental health lived experience (peer) workforce, which will be engaged in the development of future directions for the lived experience (peer) workforce in Queensland Health.

Queensland Health noted that its lived experience workforce development process will be updated to align with the new National Guidelines.[830]

7.4.5.2 Lived experience (peer) AOD workforce

Queensland Health advised that for AOD services, lived experience (peer) workers make a unique contribution in the treatment, care, and planning of services for people with problematic substance use. For example:

> …compared to other peer workforce, people with lived experiences of AOD encounter unique barriers and challenges particularly regarding stigma and discrimination and a lack of understanding of the nature of substance use including from within healthcare settings. As a person with lived experience explains "It was difficult going - because the local doctor looks at you like, ''Well, just get off it." They don't understand ... that it is a disease. They just think, just stop using it. Well, it's not that easy."[831]

In terms of growing the lived experience workforce in the AOD sector, QNADA advised:

> We have been talking with the primary health networks around how we might do some work to identify what we mean about peer workforce in our alcohol and drug space, because obviously in the harm reduction space, particularly in needle and syringe programs, it is not unusual to have people who are themselves current illicit drug users. There are obviously specific risks that need to be managed in that environment to keep them safe in that environment. It becomes a little easier to manage in the residential setting where you have people on their own recovery journey, have recovery capital and can share that with people in the service. The answer is: yes, we want more empathy in all of our service systems, and giving prominence to lived experience in those services is one way to do that.[832]

Queensland Health submitted the following priority considerations for enhancing and developing the lived experience (peer) workforce:

- recognising the role and value of the lived experience (peer) workforce including educating other health professionals about their role and value and the outcomes for people with a lived experience.
- enhancing and integrating lived experience support across state-funded mental health and AOD services.
- improving professional development for lived experience (peer) workers.
- enhancing mentoring support and supervision.

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829 Submission 80, pp 1-2.

830 Submission 150, p 65.

831 Queensland Health, submission 150, p 63.

832 Public hearing transcript, Brisbane, 16 February 2022, p 7.

- ensuring there is appropriate support for individuals with complex/specific needs, including the addition of Aboriginal and Torres Strait Islander and youth lived experience (peer) workers.
- developing a peer workforce for people experiencing problematic substance use.[833]

Committee comment

The committee supports the expansion of the lived experience workforce in line with the *Queensland Framework for the Development of the Mental Health Lived Experience Workforce* and the National Mental Health Commission's *National Lived Experience (Peer) Workforce Development Guidelines.*

In accordance with the Queensland Lived Experience Framework, the committee considers that the lived experience workforce should be developed to acknowledge unique cultural differences and the value of specialisations, including but not limited to:

- Aboriginal and Torres Strait Islander peoples
- people from culturally and linguistically diverse backgrounds
- people from the Deaf community
- people identifying as LGBTQIA+
- people with a history of trauma and/or family violence
- people with experiences of perinatal mental health
- people with experiences of eating disorders
- people with experiences of suicide
- people with experiences of involuntary treatment, incarceration and/or homelessness
- people with experiences of alcohol and other drug use or dependence
- people identifying as neurodivergent
- people with disability
- older people
- youth
- veterans.[834]

833 Submission 150, pp 65-66.

834 Queensland Mental Health Commission, *Queensland Framework for the Development of the Mental Health Lived Experience Workforce*, 2019, p 8.

Recommendation 54 – Expand and regulate Queensland's lived experience (peer) workforce

The committee recommends the Queensland Government:

a) progresses work to develop Queensland's lived experience (peer) workforce, including:
   i. the standardisation and regulation of the lived experience workforce
   ii. the evaluation and quality assurance of lived experience professional training and development.

b) works with rural and remote mental health and alcohol and other drugs services to develop and support lived experience practitioner roles in rural and remote communities.

c) increases the number of lived experience (peer) service roles in Aboriginal and Torres Strait Islander communities.

d) investigates ways to encourage the uptake of lived experience roles by working to remove barriers, for example providing scholarships and reducing TAFE costs for requisite qualifications for lived experience (peer) mental health and alcohol and other drugs roles.

7.4.6 Workforce wellbeing

The committee heard of the need to better support mental health and AOD workers, particularly in the context of increased demand on services, workforce shortages and the impact of COVID-19.[835]

The AMAQ advised the committee that more strategies and funding are needed to improve and protect the psychological wellbeing of the workforce. The AMAQ added:

> The burnout rate for medical and other healthcare practitioners has increased significantly in the last two years of the pandemic and we are anticipating significant numbers of practitioners to leave the profession—and we have already started seeing that—over the next few years as a result.[836]

The QMHC stated that serious commitment is required to address workforce wellbeing by tackling 'the known predictive and preventative factors of vicarious trauma'.[837] The QMHC added:

> 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.[838]

The committee heard from the Victorian Department of Health of its reforms to support the wellbeing and safety of the mental health workforce following the Victorian Royal Commission:

> There is a focus in the royal commission about trying to protect and enhance workforce wellbeing and safety. All states and territories have had these challenges with the pandemic. It has really had some big impacts on our workforce generally across the health system. There is a focus on really trying to enhance the wellbeing of the workforce, partly because we cannot afford to lose people from the workforce. Every day we hear that people are leaving the workforce because they can no longer be supported.[839]

835 Submission 151.

836 Public hearing transcript, Brisbane, 17 February 2022, p 10.

837 Submission 151, p 128.

838 Submission 151, p 128.

839 Public hearing transcript, Brisbane, 28 April 2022, p 4.

Committee comment

The committee acknowledges the challenges facing mental health and AOD workers in Queensland, and thanks them for their commitment to caring for people experiencing mental ill-health, suicidality and alcohol and other drug problems.

The committee notes the ongoing impacts that COVID-19 has had on Queensland's health workforce generally, but also in the mental health sector given the increasing demand for services at a time when the system was already strained.

The committee acknowledges the importance of long-term planning to ensure the viability of Queensland's mental health and AOD workforce, and the need to consider workforce wellbeing and safety strategies.

Recommendation 55 – Strategies to support the mental health and alcohol and other drugs workforce

The committee recommends the Queensland Government develops and implements strategies to foster a supportive and safe workplace culture within state-funded mental health and alcohol and other drugs services, and in partnership with non-government organisations and private sector service providers where relevant.

7.5 Meeting consumer needs

The Productivity Commission reported that consumers benefit when clinical staff spend time with them, 'talking with them, or providing treatment, for example – or when clinical staff spend time without them, but working on 'consumer-related activities', such as care coordination, clinical planning, and documenting or reviewing treatment'.[840]

The Productivity Commission noted that benefit to consumers is less clear when clinical staff spend time on non-consumer-related activities, 'which can include demonstrating compliance with regulatory requirements, program planning, and travel, in addition to professional activities such as staff supervision and evaluation'.[841]

The Productivity Commission found that clinical staff in state government community mental health services spend less than one-third of their time on consumer-related activities (ie approximately 30%)[842]. The Productivity Commission report explained:

> Using unpublished data from AIHW, we estimated that, in 2017-18, only about 29% of clinical staff time in community ambulatory care services was spent on consumer-related activities — 20% with the consumer present and 9% without the consumer present. These estimates — and especially the amount of time clinicians spend with the consumer present — varied greatly between jurisdictions...[843]

On these findings, Professor Whiteford told the committee:

> The service planning framework estimates, based on expert opinion, that it should be 67 per cent. In the private sector it is 85 per cent. There are things we need to do with our existing services now which in theory could double the amount of patient related activity that those services are doing.[844]

840 Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 571.

841 Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 571.

842 Professor Harvey Whiteford, public hearing transcript, Brisbane, 17 February 2022, p 34.

843 Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 571.

844 Public hearing transcript, Brisbane, 17 February 2022, p 34.

7.5.1 Time spent with consumers in the public system

Queensland has consistently had one of the lowest direct care FTE per 100,000 persons for mental health service provision in Australia, being below the national average for most of the last decade.[845]

Queensland Health stated:

> The 2021 Report on Government Services, shows that in 2018-19, Queensland had the second lowest direct care FTE per 100,000 persons in Australia. This is despite a growth in Queensland's investment in direct care FTE (13 per cent) which was just over double the national growth rate (six percent) between 2009-10 and 2018-19.[846]

In relation to non-consumer related activities of clinical staff, Queensland Health advised that clinical documentation of care and data collection are critical to healthcare safety and quality to track planning, provision and progress of care, legislative requirements, and support funding. According to Queensland Health, the collection of this data also informs research and evaluation to expand its evidence base and improve practices.[847]

Queensland Health explained the impact of electronic health records on time spent with consumers:

> Electronic health records have led to improvements in quality and safety, diagnostic accuracy, improved continuity of care across settings, support for visibility of key performance measures and support for guideline-based care. Despite this, there are unintended consequences of electronic health information systems including increased documentation time, with this burden itself being associated with negative impacts including errors, poor quality of documentation, reduced time with individuals receiving services, workforce retention issues and clinician burnout.[848]

Queensland Health advised that the workforce in Queensland mental health and AOD services strives daily to provide a high standard of care in the context of significant human and capital shortfalls and challenges.[849]

When asked about whether public mental health clinicians spend up to 80% of their day on non-consumer activities such as administration, Queensland Health advised:

> They do not spend 80 per cent of their time doing that. Our clinicians are very hardworking. They are seeing lots of patients every day. There are certainly some frustrations with the system, but some of that is because of the demand so any extra work feels like a huge imposition in terms of documentation.
>
> What we know is that some of that documentation and systems is incredibly important in terms of improving safety. Consumers in our services deserve comprehensive care so we do need to do this work. A lot of the work we have done around suicide prevention is absolutely not to heighten people's concern about risk; it is to support our clinicians in working collaboratively with consumers and their families to manage a lot of the risk and improve their care.[850]

845 Queensland Health, briefing paper, 1 February 2022, p 31.

846 Queensland Health, briefing paper, 1 February 2022, p 31.

847 Queensland Health, submission 150, p 46.

848 Queensland Health, submission 150, p 46.

849 Submission 150, p 7.

850 Public hearing transcript, Brisbane, 28 April 2022, p 10.

Committee comment

The committee heard evidence that staff in state-funded community mental health services spend approximately only a third of their time on consumer-related activities.[851] The committee also heard of the impact of maintaining electronic health records on time spent with consumers.[852]

The committee notes there are many factors potentially impacting on the time mental health and AOD staff in state-funded services spend with consumers, including workforce pressures, administrative systems and the impact of COVID-19. However, the committee is of the view that the Queensland Government should review administrative health systems, such as the electronic health records system, to understand their impact on non-clinical workload (ie non-consumer related activities).

Recommendation 56 – Review adminstrative health systems and their impact on non-clinical workload

The committee recommends the Queensland Government reviews administrative health systems, such as the electronic records system, to determine their impact on non-clinical workloads, and explore ways to increase clinicians' time with consumers in the public health system.

7.6 Cultural capability of mental health and AOD workforce

According to the Productivity Commission, 'language and cultural differences can be a barrier to accessing mental health services'. In particular, Aboriginal and Torres Strait Islander peoples and people from CALD backgrounds are less likely to seek and receive mental health treatments than the general population. Ensuring the cultural capability of mental health professionals is key to enabling Aboriginal and Torres Strait Islander and CALD peoples to access mental health services.[853]

The Productivity Commission found that mental health professionals should ensure their service delivery accounts for the following characteristics of some Aboriginal and Torres Strait Islander peoples and CALD people:

- lower levels of English proficiency can impact an individual's ability to navigate often complex mental health systems, and they may experience problems in communication with health professionals
- higher perceived stigma and negative attitudes towards mental illness
- lower levels of mental health literacy which may result in difficulty recognising the signs of distress in themselves (or others in the community), which can prevent them from seeking support
- heightened experience of discrimination and trauma (intergenerational or recent), which can lead to mistrust in health professionals and the medical system more broadly
- religious or spiritual beliefs that affect compliance with medication or other medical interventions.[854]

[851] Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 571; see also Professor Harvey Whiteford, public hearing transcript, Brisbane, 17 February 2022, p 34.

[852] Queensland Health, submission 150, p 46.

[853] Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 740.

[854] Productivity Commission, *Mental health inquiry report*, No. 95, 2020, vol 2, p 740.

Orygen supported the view that Aboriginal and Torres Strait Islander young peoples do not always have access to culturally safe services and to ensure this, 'dedicated focus and resourcing is required for social and emotional wellbeing initiatives and services that are led and delivered by Aboriginal and Torres Strait Islander people'.[855]

headspace, in collaboration with the Central Australian Aboriginal Congress, recommended:

> Strengthening community-led initiatives to reduce the rates of suicide requires recognising the impact of colonisation, intergenerational trauma and loss of control. This includes supporting community control of Aboriginal services and programs, connection to family, community, country, language and culture and support for trauma-informed services, healing programs, culturally secure SEWB [social and emotional wellbeing] programs and, where appropriate, Aboriginal families living on country.[856]

See also section 5.5.7: Culturally and linguistically diverse communities.

7.6.1 Achieving health equity for Aboriginal and Torres Strait Islander peoples

Aboriginal and Torres Strait Islander peoples have higher rates of suicide compared to non-Indigenous Queenslanders and are also more likely to be hospitalised for psychoactive substance misuse and other psychotic disorders. Aboriginal and Torres Strait Islander peoples experience higher levels of morbidity from mental illness, assault, psychological distress and self-harm. Mental illness is a leading contributor to the Indigenous burden of disease in Queensland, contributing up to one-fifth of the total disease burden.[857]

Stakeholders emphasised the importance of providing culturally appropriate assistance and care to Aboriginal and Torres Strait Islander peoples, including developing 'an understanding of Aboriginal and Torres Strait Islander history, particularly the impact of colonisation on present day grief, loss and trauma and its complexity'.[858] headspace stated that 'there is a direct relationship between poor mental health and wellbeing, and lack of access to land, culture, identity, self-worth and the breakdown of traditional kinship structures and roles within communities'. headspace stated further:

> For many decades Aboriginal and Torres Strait Islander people and communities have argued for accessible and appropriate mental health care to address the enduring mental health impacts of intergenerational trauma as the result of colonisation, racism, dispossession, discrimination, and marginalisation.[859]

The state-funded mental health and AOD system contributes to the aims and targets of the *Making Tracks towards health equity with Aboriginal and Torres Strait Islander peoples – working together to achieve life expectancy parity by 2031* and the *National Agreement on Closing the Gap (2020).* For mental health and AOD, this includes:

> …developing and implementing ongoing strategies to reduce health inequities, improve cultural quality and safety, leadership by and partnerships with Aboriginal and Torres Strait Islander agencies, services, stakeholders and communities and the commissioning of MHAOD and social and emotional wellbeing services from the Aboriginal and Torres Strait Islander health services sector.[860]

855 Submission 73, p 6.

856 Submission 66, p 19.

857 Queensland Health, briefing paper, 1 February 2022, p 29.

858 Suicide Prevention Australia, submission 25, p 20; Anglicare SQ, submission 41, p 34; Australian Counselling Association, submission 51, p 16.

859 Submission 66, p 13.

860 Queensland Health, briefing paper, 1 February 2022, p 29.

Queensland Health advised that Queensland's Aboriginal and Torres Strait Islander Health Equity Framework places Aboriginal and Torres Strait Islander peoples and voices at the centre of healthcare service design and delivery in Queensland.[861]

7.6.1.1 Aboriginal and Torres Strait Islander health workforce

Queensland's Aboriginal and Torres Strait Islander Health Equity Framework has been enacted in legislation through provisions in the *Hospital and Health Boards Act 2011* and the Hospital and Health Boards Regulation 2012.[862]

Ms Haylene Grogan, Chief Aboriginal and Torres Strait Islander Health Officer and Deputy-Director General in Queensland Health, explained how the legislation will assist in developing the Aboriginal and Torres Strait Islander health workforce:

> It is about reshaping local health systems with First Nations people. First Nations representation that is the voice on each hospital and health board is now a legal requirement, along with our first-ever health equity strategies, which are being co-designed by each of our 16 HHSs, with the community controlled sector, our First Nations staff, local elders, traditional owner custodians and community. That is also a legal requirement. Each HHS is legally required to have a First Nations workforce—that is, our people—proportionate to the First Nations population they serve across every workforce level and every workforce category. Our reforms to achieve health equity, that is, designing and delivering health care with First Nations people, is historic. It not only includes improving mental healthcare services but also improving the coordination of those services. Significantly, each HHS is now also legally required to deliver culturally appropriate health care that First Nations people need and want.[863]

Committee comment

The committee acknowledges the importance of the representation of Aboriginal and Torres Strait Islander peoples in mental health and AOD service delivery. The committee has heard from Aboriginal and Torres Strait Islander Queenslanders that developing the Aboriginal and Torres Strait Islander health workforce will contribute to building a service delivery system that better responds to the needs of Aboriginal and Torres Strait Islander peoples.

The committee also heard evidence about developing the health workforce by creating pathways to certificate training to work in mental health and alcohol and other drugs service roles: for example, a Certificate IV in Mental Health, Alcohol and other Drugs or Mental Health Peer Work. To this end, the committee encourages the Queensland Government to support greater representation of Aboriginal and Torres Strait Islander peoples within the mental health workforce through the funding of scholarships.

Recommendation 57 – Expand the Aboriginal and Torres Strait Islander mental health and alcohol and other drugs workforce

The committee recommends the Queensland Government funds scholarships to support Aboriginal and Torres Strait Islander peoples to attain accreditation to work in mental health and alcohol and other drugs service roles.

861 Queensland Health, briefing paper, 1 February 2022, pp 29-30.

862 Queensland Health, briefing paper, 1 February 2022, p 30.

863 Public hearing transcript, Brisbane, 11 February 2022, p 34.

Appendix A – Submitters

Sub #	Submitter
001	Michael Wright
002	Tim Sayre
003	Professor Dan Siskind
004	Associate Professor James Morton AM
005	Bob Green
006	Family Drug Support (FDS)
007	Dr Richard Lakeman
008	Darryl Nelson
009	Joe Rocco
010	Lorna Pitt
011	Name withheld
012	Lived Experience Australia
013	Dr Stefanie Roth
014	Dr Lesley van Schoubroeck
015	David Harris
016	Dave Cheethman
017	Name withheld
018	Name withheld
019	David Murray
020	John Favaro
021	Adrian Carroll
022	Name withheld
023	Darryl Nelson
024	Karen Hvidding
025	Suicide Prevention Australia
026	Robyn Knight
027	OzHelp
028	Youth Empowered Towards Independence
029	Mental Health Review Tribunal
030	Shane Bouelscript for audio submission
031	Elizabeth O'Keefe
032	Shane Hicks
033	Niall McLaren

034 Confidential
035 Tropical Brain and Mind Foundation
036 Cassie Greco
037 Jonathan Nicholls
038 Occupational Therapy Australia
039 Name withheld
040 Diabetes Queensland
041 Anglicare Southern Queensland
042 Youth Flourish Outdoors Ltd
043 Outback Futures
044 Confidential
045 Tori Clough
046 Office of the Public Guardian
047 J D Thompson
048 Queensland Network of Alcohol and Other Drug Agencies Ltd
049 Dietitians Australia
050 Melissa Costin
051 Australian Counselling Association
052 Exercise and Sports Science Australia
053 Care Opinion Australia
054 Justine Lawson
055 Lionel Kerr
056 Sonya Hill
057 Roses in the Ocean
058 Nikita Kotlarov
059 World Wellness Group
060 Therese Anderson
061 Chris Lightbody
062 Name withheld
063 Australian Psychological Society
064 batyr Australia Limited
065 Kristine Simmonds
066 headspace
067 Zero Suicide Institute of Australasia
068 Department of Developmental Disability Neuropsychiatry, UNSW Medicine and Health

069 Alcohol and Drug Foundation
070 Confidential
071 Rural Health Connect
072 Name withheld
073 Orygen
074 yourtown
075 QulVAA
076 Dr. Narelle Dawson-Wells
077 Confidential
078 Brisbane Housing Company Limited
079 Mind Australia Limited
080 Queensland Lived Experience Workforce Network
081 Common Ground Queensland
082 Queensland Police Service
083 Wesley Medical Research
084 Confidential
085 DVConnect
086 QPASTT
087 Brisbane South Primary Health Network
088 Mental Illness Fellowship Australia
089 Springfield City Group
090 Inala Primary Care
091 The Migrant Centre Organisation Inc trading as Thriving Multicultural Communities (TMC)
092 Citizens Commission on Human Rights
093 Wesley Medical Research & Outback Futures - Joint submission
094 Julieann Conway
095 Palliative Care Queensland
096 Eating Disorders Queensland
097 MATES in Construction
098 GROW Australia
099 Professor Neeraj Gill
100 Dr Amy MacMahon MP, Member for South Brisbane
101 Arafmi Ltd and Carers Queensland
102 Peach Tree
103 Australian Association of Social Workers

104 Australian Medical Association of Queensland

105 Peer Participation in Mental Health Services

106 Name withheld

107 Primary Health Networks Queensland

108 Allan Fels

109 Rebecca Sferco

110 Australian Association of Psychologists Inc

111 Triple P International Pty Ltd

112 Queensland Nurses and Midwives Union

113 Workers' Psychological Support Service

114 Prevention United

115 Australian College of Mental Health Nurses

116 PEP Health

117 Name withheld

118 Deaf Connect

119 Queensland Alliance for Mental Health

120 Australian College of Nurse Practitioners

121 Queensland Catholic Education Commission

122 Christine Newton

123 Wellways Australia

124 Australian Veterinary Association

125 Cancer Council Queensland

126 Lung Foundation Australia, Arthritis Queensland and Cancer Council Queensland

127 Queensland Aboriginal and Islander Health Council

128 Queensland Family & Child Commission

129 Mater Young Adult Health Centre

130 Mater Intellectual Disability and Autism Service (MIDAS), Mater and the Queensland Centre for Intellectual and Developmental Disability (QCIDD), Mater Research Institute-UQ

131 Micah Projects

132 Name withheld

133 Mental Health Lived Experience Peak Queensland

134 The Salvation Army

135 Queensland Sexual Violence Network

136 Ramsay Mental Health

137 Institute for Urban Indigenous Health (IUIH)

138 Office of the Health Ombudsman

139 Aged and Disability Advocacy Australia

140 The Royal Australian and New Zealand College of Psychiatrists Queensland Branch

141 Australian Research Alliance for Children and Youth & Thriving Queensland Kids Partnership - Joint submission

142 Kim Taylor

143 The Public Advocate

144 Mater HealthPerinatal Mental Health

145 Queensland Council for LGBTI Health

146 Rainbow Families Queensland

147 Grace Homestead Recovery Centre

148 Q Shelter

149 Name withheld

150 Queensland Health

151 Queensland Mental Health Commission

152 Drug ARM Queensland

153 Fishability QLD

154 YFS Ltd

155 Office of Industrial Relations, Department of Education

156 Confidential

157 Jonty Bush MP, Member for Cooper

158 Sisters Inside Inc

159 Mia Pattison

160 Moira McNeil

161 e-Mental Health in Practice (eMHPrac), Queensland University of Technology

162 National Disability Insurance Agency

163 Department of Environment and Science

164 Bravehearts

Appendix B – Officials at public departmental briefing

20 January 2022

Queensland Health

- Associate Professor John Allan, Executive Director, Mental Health Alcohol and Other Drugs Branch
- Ms Liza-Jane McBride, Chief Allied Health Officer
- Ms Deborah Millar, Chief Nursing and Midwifery Officer
- Dr John Reilly, Chief Psychiatrist

Queensland Ambulance Service

- Ms Sandra Garner, Director, Mental Health Response Program

Queensland Mental Health Commission

- Mr Ivan Frkovic, Commissioner, Queensland Mental Health Commission
- Dr Simone Caynes, Director, Systems Planning and Response
- Ms Giovanna Franze, Project Manager, Office of the Commissioner

11 February 2022

Department of Children, Youth Justice and Multicultural Affairs

- Mr Phillip Brooks, Deputy Director-General, Youth Justice
- Dr Meegan Crawford, Chief Practitioner
- Ms Rebecca Maurer, Practice Leader, Mental Health
- Ms Helen Missen, Acting Executive Director, Strategic Policy and Legislation

Department of Education

- Dr Beth McInally, Director, Student Wellbeing, State Schools Operations
- Mrs Hayley Stevenson, Acting Assistant Director-General, State Schools Operations

17 February 2022

Queensland Health

- Associate Professor John Allan, Executive Director, Mental Health Alcohol and Other Drugs Branch
- Mr Shaun Drummond, then Chief Operating Officer

Queensland Treasury

- Mr Leon Allen, Under Treasurer
- Mr Dennis Molloy, Acting Deputy Under Treasurer, Economics and Fiscal

Queensland Mental Health Commission

- Mr Ivan Frkovic, Commissioner

Appendix C – Witnesses at public hearing

27 January 2022

Stepping Stone Clubhouse

- Ms Melanie Sennett, Executive Director
- Mr Brian Goodall, Committee Member
- Mr Harley Johnman, Member
- Mr Harley Johnman, Member
- Ms Kerrin Dickinson, Member
- Mr Michael Cullen, Member
- Ms Martina McGrath, Member

Peer Participation in Mental Health Services

- Mr Joe McCartney, Member

Private capacity

- Ms Lyn Knight
- Ms Maricar Gobelsa

11 February 2022

Queensland Family and Child Commission

- Ms Natalie Lewis, Commissioner
- Ms Holly Hudson, Youth Advocate
- Ms Alyssa Ikefuji, Youth Advocate
- Ms Grace Sholl, Youth Advocate

Independent Schools Queensland

- Ms Jacky Dawson, Senior Adviser, Student Services
- Mr Christopher Mountford, Chief Executive Officer

Queensland Catholic Education Commission

- Dr Shannon O'Gorman, Education Officer
- Dr Lee-Anne Perry, AM, Executive Director

Mater Young Adult Health Centre

- Dr Simon Denny, Director
- Mr Greg McGahan, Senior Manager, Young Adult and Mental Health Services

QIMR Berghofer Medical Research Institute

- Professor James Scott, Group Leader, Child and Youth Research Group

Children's Health Queensland Hospital and Health Service

- Associate Professor Stephen Stathis, Medical Director, Child and Youth Mental Health Service

- Adjunct Professor Frank Tracey, Health Service Chief Executive

Queensland Centre for Perinatal and Infant Mental Health

- Dr Elisabeth Hoehn, Medical Director
- Ms Sarah Davies-Roe, Coordinator, Perinatal and Infant Mental Health Early Years Project

Private capacity

- Professor Dan Siskind, Professor of Psychiatry

Queensland Aboriginal and Islander Health Council

- Mr Cleveland Fagan, Chief Executive Officer
- Mr Bevan Ah Kee, General Manager

Queensland Health

- Ms Haylene Grogan, Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General, Aboriginal and Torres Strait Islander Health Division
- Ms Kimina Anderson, Director, Aboriginal and Torres Strait Islander Health, Aboriginal and Torres Strait Islander Health Division

16 February 2022

Queensland Network of Alcohol and Other Drugs Agencies Ltd

- Ms Rebecca Lang, Chief Executive Officer
- Ms Sue Pope, Deputy Chief Executive Officer
- Mr Sean Popovich, Director, Policy and Systems

Alcohol and Drug Foundation

- Dr Erin Lalor, Chief Executive Officer
- Mr Martin Milne, State Manager, Queensland

Drug ARM Queensland

- Mr Richard Norman, Clinical and Service Development Manager
- Dr Dennis Young AM, Chief Advocate

17 February 2022

Brisbane South Primary Health Network

- Mr Mike Bosel, Chief Executive Officer, Brisbane South Primary Health Network

Western Queensland Primary Health Network

- Ms Sandy Gillies, Chief Executive Officer

Brisbane North Primary Health Network

- Mr Paul Martin, Executive Manager

Royal Australian College of General Practitioners, Queensland Branch

- Dr Edwin Kruys, Representative

Australian Medical Association Queensland

- Dr Chris Perry OAM, President, Australian Medical Association Queensland
- Dr Bavoharan Manoharan, Vice President

Orygen

- Professor Pat McGorry, Executive Director

Productivity Commission

- Dr Stephen King, Commissioner

Private capacity

- Professor Harvey Whiteford

Queensland Mental Health Commission

- Mr Ivan Frkovic, Commissioner

Toowong Private Hospital

- Ms Christine Gee, Chief Executive Officer

Ramsay Mental Health Australia

- Ms Anne Mortimer, Director

Belmont Private Hospital

- Ms Mary Williams, Chief Executive Officer and Director of Clinical Services

18 February 2022

Carers Queensland

- Mrs Sarah Bone, Manager, Carer Program
- Ms Sarah Walbank, Manager, Quality & Assurance

Association of Relatives & Friends of the Mentally Ill

- Ms Irene Clelland, Chief Executive Officer
- Ms Alexandra Tyson, Service Delivery Manager, Carer Supports
- Dr Alexis Wallace, Member, Carer Advisory Committee

Roses in the Ocean

- Ms Bronwen Edwards, Chief Executive Officer

Private capacity

- Associate Professor Dr James Morton AM
- Mrs Louise Morton

7 March 2022

Private capacity

- Mr Tim Sayre

Indigenous Wellbeing Centre

- Ms Kathy Clarke, Chief Operations Officer

Wide Bay Hospital and Health Service

- Dr Roy West, Clinical Director, Mental Health Services (Bundaberg and Rurals)
- Ms Robyn Bradley, Executive Director, Mental Health and Specialised Services
- Ms Clarissa Schmierer, Program Manager, Mental Health and Alcohol and Drug Services (Bundaberg and Rurals)

Impact Community Services

- Mr Steven Beer, General Manager, Health and Support

Bridges Health & Community Care

- Ms Sharon Sarah, Chief Executive Officer

8 March 2022

Hervey Bay Neighbourhood Centre

- Ms Tanya Stevenson, Chief Executive Officer

Fraser Coast Mates

- Mr Darren Bosley, President
- Mr Peter Grumley, Committee Member

Flourish

- Ms Debra Gibbons, Regional Manager
- Mr Trevor Matthews, Regional Manager

Galangoor Duwalami Primary Healthcare Service

- Mr Stevan Ober, Chief Executive Officer

10 March 2022

Queensland Family and Child Commission

- Mr Luke Twyford, Principal Commissioner
- Ms Jessy Renouf, Youth Advocate

headspace National Youth Mental Health Foundation

- Mr Jason Trethowan, Chief Executive Officer
- Ms Naraja Clay, Board Youth Adviser

Lives Lived Well

- Ms Rosemary Spencer, Clinical Lead, headspace Upper Coomera

Open Minds Australia Ltd

- Mr James Thompson, Regional Manager, Service Delivery, Allied Health

Peer Participation in Mental Health Services Network

- Ms Paula Arro, Chairperson
- Ms Viv Kissane, Chief Executive Officer, Peach Tree Perinatal Wellness
- Ms Tina Pentland, Carer/Family Member Representative

Care Opinion Australia

- Professor Michael Greco, Chief Executive Officer and Founder
- Ms Alicia Reid, Patient Experience Lead, Operations Manager
- Ms Rebecca Somerville, Client Liaison Officer

Queensland Alliance for Mental Health

- Ms Jennifer Black, Chief Executive Officer
- Ms Sarah Childs, Director, Sector Engagement and Development
- Ms Emma Griffiths, Director, Advocacy and Communications
- Ms Sally McLeod, Project and Policy Officer

Mental Health Lived Experience Peak Queensland

- Mr Jorgen Gullestrup, Chief Executive Officer
- Ms Naraja Clay, Person with lived experience
- Mx Rosiel Elwyn, Person with lived experience

Australian Psychological Society

- Dr Linda De George-Walker, Senior Policy Advisor
- Dr Alexandra Murray, Senior Policy Advisor

Queensland Nurses and Midwives' Union

- Ms Beth Mohle, Union Secretary
- Ms Julie Lee, Research and Policy Officer
- Ms Katrina Cox, Member
- Mr Chris Dawber, Member

Australian College of Mental Health Nurses

- Mr Jason Harrison, National Secretary
- Ms Vicki Green, Director
- Ms Tracey Mackle, Member, Nurse Practitioner, Credentialed Mental Health Nurse
- Mr Rick Bastida, Member, South Queensland Branch

Australian Association of Social Workers

- Mr Charles Chu, Social Policy and Advocacy Officer
- Mr James Newton, Accredited Clinical and Accredited Mental Health Social Worker

Australian Association of Psychologists Inc.

- Ms Amanda Curran, Chief Services Officer
- Ms Tegan Carrison, Executive Director

11 March 2022

Brisbane Housing Company

- Ms Megan Bonetti, Senior Community Development Manager

- Ms Kaitlyn Russell, Community Development Manager

Q Shelter

- Ms Fiona Caniglia, Executive Director

Common Ground Queensland

- Ms Sonya Keep, Chief Executive Officer
- Mr Mark Neave, Board Director

DVConnect

- Ms Rebecca O'Connor, Chief Executive Officer
- Dr Kelly Dingli, Head of Clinical Practice
- Ms Michelle Royes, Manager

Suicide Prevention Australia

- Ms Nieves Murray, Chief Executive Officer
- Mr Matthew McLean, Director, Policy and Government Relations
- Mx Caitlin Bambridge, Senior Policy Adviser

Eating Disorders Queensland

- Ms Belinda Chelius, Chief Executive Officer
- Ms Rohie Marshall, Care Navigator and Public Health Lead
- Ms Megan Bray, Dietician and Senior Mentor

Queensland Sexual Assault Network

- Ms Sara Pane, Senior Practitioner, Sexual Assault Program, Zig Zag Young Women's Resource Centre Inc; Member

Institute for Urban Indigenous Health

- Mr Adrian Carson, Chief Executive Officer
- Dr Carmel Nelson, Clinical Director
- Ms Marianna Serghi, Strategic Policy Adviser

Rainbow Families Queensland

- Ms Matilda Alexander, Steering Committee Member
- Mr Trevor Kanapi, Steering Committee Member

Queensland Council for LGBTI Health

- Ms Rebecca Reynolds, Chief Executive Officer
- Mr Benjamin Dawson, Communities and Partnerships Liaison Officer

Thriving Multicultural Communities, The Migrant Centre Organisation Inc.

- Ms Zeljana (Anna) Zubac, Executive Director
- Ms Gordana Blazevic, Consultant
- Ms Joyce Cho, Principal Settlement and Community Development Coordinator

Queensland Program of Assistance to Survivors of Torture and Trauma

- Ms Jamila Padhee, Chief Executive Officer
- Ms Magdalena Kuyang, Counsellor
- Ms Zainab Sakha, Community based trauma recovery practitioner

Inala Primary Care

- Ms Tracey Johnson, Chief Executive Officer
- Dr David Chua, Research, Audits and Collaboration Manager
- Dr Stephanie Chua, General Practitioner

World Wellness Group

- Mr Hamzai Vayani, Chair and Board Director
- Ms Rita Prasad-Ildes, Managing Director
- Ms Sameera Suleman, Manager, Multicultural Connect Line

18 March 2022

Mirikai Transformations Gold Coast

- Mr Michael Barrett, Chief Executive Officer

Salvation Army

- Ms Harriet Crisp, State Manager, AOD Queensland
- Mr Aaron Pimlott, State Manager, Homelessness Queensland

Gold Coast Youth Service

- Ms Maria Leebeek, Chief Executive Officer
- Mr Matt Slavin, Team Leader, Gold Coast Foyer

Accoras Gold Coast

- Ms Susan Lewis, General Manager, Strategy, Innovation and Research

Gold Coast Hospital and Health Service

- Ms Michelle Sanders, Team Leader, Lived Experience (Peer) Workforce
- Ms Angela Davies, Senior Peer Coordinator, Lived Experience (Peer) Workforce

12 April 2022

Queensland Police Service

- Mr Peter Brewer, Acting Assistant Commissioner, Domestic, Family Violence and Vulnerable Persons Command

Office of Industrial Relations

- Mr Tony James, Acting Deputy Director-General
- Ms Yasmin Cox, Executive Director, Specialised Health and Safety Services
- Ms Jodie Deakes, Executive Director, WHS Engagement and Policy Services
- Ms Janene Hillhouse, Executive Director, Workers' Compensation Regulatory Services

Workers' Psychological Support Service

- Ms Karina Maxwell, Senior Social Worker
- Revill, Ms Marnee, Social Worker

Department of Communities, Housing and Digital Economy

- Ms Irene Violet, Deputy Director-General, Communities
- Ms Mary-Anne Curtis, Associate Director-General, Housing and Homelessness Services
- Ms Madonna Cuthbert, Acting Executive Director, Programs, Housing and Homelessness Services
- Ms Sharon Kenyon, Acting General Manager, Service Delivery, Housing and Homelessness Services

Australian Counselling Association

- Mr Elliott Ainley, Industry Liaison Officer

Aged and Disability Advocacy Australia

- Mr Geoff Rowe, Chief Executive Officer
- Ms Vanessa Krulin, Solicitor, Senior Policy and Research Advisor

Zero Suicide Institute of Australasia

- Ms Susan OAM Murray, Managing Director

Office of the Public Advocate

- Dr John Chesterman, Public Advocate
- Ms Tracey Martell, Acting Manager

Mater Intellectual Disability and Autism Service and the Queensland Centre for Intellectual and Developmental Disability

- Dr Cathy Franklin, Director
- Dr Katie Brooker, Senior Researcher

Royal Australian and New Zealand College of Psychiatrists

- Professor Brett Emmerson AM, Chair, Queensland Branch Committee

13 April 2022

Grace Homestead

- Ms Zoe Knorre, Founder and Chief Executive Officer
- Ms Christine Eckert, Member, Board of Directors and Director, Research and Development

Queensland Injectors Voice for Advocacy and Action

- Mrs Emma Kill, Chair
- Ms Niki Parry, Treasurer
- Ms Rebecca Kavanagh, Board Member

Cancer Council Queensland

- Dr Lorraine Bell, Senior Policy Adviser

- Ms Brigid Hanley, Senior Manager, Cancer Support Services

Lung Foundation Australia

- Ms Kirsten Phillips, General Manager, Consumer Programs and Partnerships

Arthritis Queensland

- Ms Emma Thompson, Chief Executive Officer

Mental Illness Fellowship Australia

- Mrs Hayley Abell, Director of Strategy and Advocacy

Grow Australia

- Mr David Butt, National Chief Executive
- Mrs Sharon Friel, Regional Manager, Eastern Australia

Rural Health Connect

- Ms Megan Gomez, Director

Outback Futures

- Mr Brent Sweeney, Chief Executive Officer

Wesley Medical Research

- Dr Claudia Giurgiuman, Chief Executive Officer
- Mrs Kelly McGrath, Mental Health Care Navigator, Navicare

Cooktown District Community Centre

- Ms Karen Price, Chief Executive Officer

Mater Health—Perinatal Mental Health

- Mr Greg McGahan, Senior Manager, Young Adult and Mental Health Services
- Dr Grace Branjerdporn, Lead Clinician, Mental Health, Alcohol and Other Drugs
- Dr Majella Henry, General Practitioner, Parent Education Support

Peach Tree

- Mrs Viv Kissane, Founder and Chief Executive Officer
- Mrs Rani Farmer, Operations Manager

20 April 2022

South Burnett CTC Inc

- Ms Nina Temperton, Chief Executive Officer
- Ms Lee-Anne Reinbott, Team Leader, Family and Child Connect
- Mr Nick Krauksts, Team Leader, Youth Services
- Mr Hayden Mashford, Residential Team Leader

South Burnett Regional Council

- Ms Margie Hams, Youth Mental Health Coordinator

Kingaroy Chamber of Commerce & Industry

- Mr Damien Martoo, President

Bunyarra Counselling and Mediation

- Mr Michael Sanford, Counsellor, Principal Practitioner and Director

28 April 2022

Victoria Department of Health

- Ms Katherine Whetton, Deputy Secretary, Mental Health and Welling Division

Queensland Health

- Associate Professor John Allan, Executive Director, Mental Health Alcohol and Other Drugs Branch
- Mr Kieran Kinsella, Executive Director, Addictions and Mental Health, Metro South Health
- Dr Kathryn, Executive Director, Metro North Mental Health

Queensland Mental Health Commission

- Mr Ivan Frkovic, Queensland Mental Health Commissioner
- Ms Amelia Callaghan, Executive Director
- Ms Giovanna Franze, Project Manager, Officer of the Queensland Mental Health Commissioner

Lives Lived Well

- Mr James Curtain, Clinical Director
- Mr Mitchell Giles, Chief Executive Officer
- Ms Leanne Hides, Professor of Alcohol, Drugs and Mental Health

Exercise & Sports Science Australia

- Ms Anita Hobson-Powell, Chief Executive Officer
- Mr Matthew Byrne, Accredited Exercise Physiologist

ATUNE Health Centres

- Mr Simon Ashley, Chief Executive Officer

Broncos Wellbeing and Resilience Training Program

- Mr Darius Boyd, Brisbane Broncos Ambassador, Broncos Wellbeing and Resilience Program Facilitator
- Miss Katherine Jurd, Broncos Community Programs Manager

Queensland Forensic Mental Health Service

- Dr Ed Heffernan, Director

29 April 2022

Women's Health & Equality Queensland

- Ms Emma Iwinska, Chief Executive Officer

Torres and Cape Hospital and Health Service

- Miss Dawn Miller, Acting Director, Mental Health, Alcohol and Other Drugs Service
- Mr Samuel Schefe, Director, Mental Health, Alcohol and Other Drugs Service

Occupational Therapy Australia

- Mr Adam Lo, Board Member

Office of the Health Ombudsman

- Dr Lynne Coulson Barr, Health Ombudsman
- Ms Karen Grogan, Director, Triage and Assessment, Assessment and Resolution

Private capacity

- Ms Laura Lewis
- Mr Darryl Nelson
- Ms Mia Pattison

Statements of Reservation

Amy MacMahon MP
Member for South Brisbane

3 June 2022

Statement of Reservation - Member for South Brisbane
Inquiry into the opportunities to improve mental health outcomes for Queenslanders

I thank the Mental Health Select Committee for the opportunity to make this Statement of Reservation. I'd also like to thank the Secretariat, and well as my fellow committee members, for their hard work, and thank the many stakeholders and individuals who offered their time and insights to what is often a very difficult topic. Many stakeholders expressed their hope that this inquiry would result in real change, and that their voices would truly be heard - I hope this report lays the groundwork for a cross-government commitment to funding and structuring the mental health sector, and our communities more broadly, in a way that truly supports Queenslanders to live their best lives.

Despite the tight timeframes, the Committee connected with a wide range of stakeholders and individuals across the state. The resulting report offers an in-depth look at the state of the mental health sector in Queensland, and the recommendations broadly reflect the issues and needs addressed by these stakeholders. However, there are a number of gaps that myself and the Greens feel deserve attention.

Our mental health system, like so many social support systems in Queensland, is simply not funded to meet the mental health challenges that are so present in our community.

Every piece of evidence that this inquiry has heard has supported this.

With only weeks until the 2022-23 state budget which will show soaring government revenue off the back of demand for our natural resources, it is time for us to invest in the mental health system.

We need to ensure that the excellent work of the many workers in the mental health system is resourced to succeed, so that Queenslanders can live the lives that they deserve.

My recommendations that are additional to those of the Committee are detailed below.

Amy MacMahon MP
www.amymacmahon.com
1/90 Vulture Street
West End Qld, 4101
(07) 3724 9100
south.brisbane@parliament.qld.gov.au
fb.com/AmyMacSouthBris

The need for further review

It should be noted that, prior to the announcement of this inquiry, the mental health sector in Queensland was campaigning for a year-long, independent inquiry into funding arrangements for mental health in Queensland.

In lieu of that, the government announced a Mental Health Select Committee comprised of parliamentarians, with the task of conducting an inquiry in the first 6 months of 2022. The reality is this was far too short a timeframe for the task.

The need for an independent inquiry into funding arrangements persists, and so an independent inquiry should be conducted into the implementation of the present inquiry, with a specific focus on government funding. The inquiry should go for at least 12 months.

Recommendation 1: an independent inquiry should be conducted into the implementation of the present inquiry, with a specific focus on government funding. It should commence by 1 July 2026 and be completed by 30 June 2027.

Specific funding

Further to the Committee's recommendation that the Queensland government increases funding and expenditure for mental health and alcohol and other drugs services in Queensland, we need to be specific about what funding is required.

As the report sets out, health expenditure per capita has increased in Queensland in recent years, but there has not been a corresponding increase in mental health expenditure. Over the past decade, it has been below the national average. In 2019-20, Queensland had the lowest per-capita expenditure on mental health services in Australia. In a state as wealthy as Queensland, this is indefensible.

In the public hearing on 17 February 2022, Professor John Allan, Executive Director, Queensland Health stated the relevant planning framework would indicate about $900 million per year is necessary in order to be fully realised.[1]

[1] Public briefing transcript, Brisbane, 17 February 2022, page 10.

In its submission to this inquiry, the Royal Australian & New Zealand College of Psychiatrists (RANZCP) recommended 'a recurrent annual funding increase of up to $750 million per year' in line with how the Victorian government responded to its Royal Commission into Victoria's Mental Health System.[2] This is in addition to its call for an 'immediate funding increase of $88 million per year to bring Queensland mental health spending up to the national average.'

The Australian Medical Association Queensland (AMAQ) called for a similar amount, noting that the $850 million per year that the Victorian government invested would translate to about $650 to $700 million per year in Queensland.[3]

The expert submitters to this inquiry took the time to cost their proposals, and estimate how much funding would be required to fix our mental health system. Accordingly, the Mental Health Select Committee needs to recommend an annual recurrent funding increase to properly resource our mental system.

Recommendation 2: the Queensland Government should provide a funding increase of between $650 million and $900 million per year in annual recurrent funding for mental health and alcohol and other drugs services in Queensland.

Revenue

The Committee considered revenue proposals in detail, with particular reference to the Mental health and wellbeing surcharge levied by the Victorian government to fund its mental health system, which was a recommendation of the Royal Commission into Victoria's Mental Health System.

This surcharge is a levy on payroll tax: companies paying Victorian taxable wages, whose Australian wages exceed $10 million. It's 0.5% of a company's Victorian taxable wages over $10 million and an additional 0.5% on a company's Victorian taxable wages over $100 million.

A payroll tax levy isn't the Queensland Greens' preferred option for raising revenue, given our long-standing concerns with payroll tax in general: we want to be encouraging jobs and higher wages, not taxing them. It's Queensland Greens policy to phase payroll tax out. Some big companies in Queensland are already exempt, and the Queensland government offered payroll tax relief to businesses in 2020 and 2021, to take the edge off COVID-19 pandemic impacts.

[2] https://documents.parliament.qld.gov.au/com/MHSC-1B43/IQ-5DEF/submissions/00000140.pdf
[3] Australian Medical Association Queensland, public hearing transcript, Brisbane, 17 February 2022, p 9.

Some businesses are now paying off deferred payroll tax. Overall, we think it's an inefficient tax which unfairly hampers small business. At the very least, we would like to see consideration given to the Western Australian model of a progressive payroll tax.

The recommendation (Rec 1) for additional funding streams could include:

- **Increasing mining royalties.** Mining profits are peaking due to a metal boom.[4] Metallurgical coal, in particular, has surged in value following geopolitical developments including the Russian invasion.[5] Instead of continuing the freeze on mining royalties enacted in 2019, the Queensland government should increase mining royalties in order to ensure the astronomical profits made by the mining industry are shared for the good of the community.
- **A big bank levy.** Across the past year, cash profits have continued to surge for the big four banks, with a combined cash profit of $14.4 billion in the 2022 half-year results.[6] Even a modest levy of 0.05% on the biggest five banks in Queensland would be enough to fund the $900 million yearly funding increase required.
- **Taxing developers.** The development industry is also booming, with no signs of slowing down before the 2032 Olympics. As the housing shortage continues and developers continue to profit, a developer tax on land value gains from upzoning should be enacted, and applying to those redeveloping the land.

Recommendation 3: that the Queensland Government raises revenue from the mining, banking and development industries in order to fund the mental health system, and the other social support systems that intersect with it.

Alcohol and other drugs, including a health-based response to drugs

The committee heard powerful evidence about the value of the alcohol and other drugs sector, and how woefully underfunded it is. In addition to increasing funding for alcohol and other drugs services in line with recommendations in this document and the Committee report, many expert submitters suggested the removal of criminal penalties for possession of drugs - decriminalisation. Careful consideration should be given to the spectrum of approaches which

4 https://miningdigital.com/supply-chain-and-operations/imarc-mining-profits-reach-new-high-due-metal-boom

5 https://inqld.com.au/business/2022/04/04/enjoy-the-mining-and-gas-boom-because-the-bust-is-coming/

6 https://www.abc.net.au/news/2022-05-10/big-four-banks-profits-home-loans-mortgage-debt-interest-rates/101051100

fall under the umbrella of a health-based response to drugs, from diversion programs to decriminalisation to legalisation.

In its submission to this inquiry, the Queensland Network of Alcohol and Other Drug Agencies (QNADA) suggested decriminalisation as a prudent strategy which reduces the investment required over time to process people through the criminal justice system.

Many organisations gave evidence about how interactions with police can exacerbate mental health issues, or criminalise people unnecessarily, including the Queensland Forensic Mental Health Service, the Alcohol and Drug Foundation and Quivva.

As Sisters Inside wrote in their submission to this inquiry, the 'vast majority of women and girls in prison are charged with minor, non-violent offences, such as theft and drug use, which have their roots in racism, trauma and mental illness.'

We must invest in systems to improve, or reduce, the interactions between people with mental illness and related illnesses, and the justice system. Strategies should include a health-based, harm reduction approach including prevention and early interventions, pill testing, training, diversionary programs and centres, strengthening of First Nations check-in programs, reducing the number of First Nations and other children in out of home care, and decriminalisation of drugs and intoxication.

Recommendation 4: invest in a health-based, harm reduction approach including prevention and early interventions, pill testing, training, diversionary programs and centres, strengthening of First Nations check-in programs and decriminalisation of drugs and intoxication.

Social determinants of health

The Committee also heard evidence regarding the social determinants of health, including the impacts of poverty, housing stress, and broader societal factors around gender, ethnicity and sexuality. The report acknowledges populations at greater risk, including households living in poverty, indigenous populations, people experiencing discrimination and conflict, and the LGBTIQ+ community. However, there is more that the Queensland government could be doing to address the social determinants of health directly, for all Queenslanders.

With regards to housing, the report acknowledges the links between access to safe, secure affordable housing and health outcomes. The report recommends (Rec 8) that the government investigate and implement options for public, community and affordable housing and supportive housing, and "progresses rental reform".

The scale of the housing crisis, and the impact that this is having on the physical and mental health of Queenslanders, warrants a much stronger recommendation from the committee, to address this need. There are nearly 50,000 people waiting for social housing, including thousands of children. The government should be urgently building and purchasing homes to make available through the Department of Communities, Housing and Digital Economy, including homes that are disability accessible. In addition, the government need to be urgently progressing rental and housing reform including:

- Instigating rent caps.
- Removing end of lease or sale of a home as grounds for eviction and moving towards long term leases.
- Advocating to the Federal government to limit negative gearing and other benefits for investors.

In addition, the committee heard evidence on the impacts of poverty, from stakeholders including Sisters Inside, The Salvation Army, Anglicare and Inala Primary Care, and many that acknowledged unemployment or underemployment as major risk factors. Sisters Inside stated 'It is abundantly clear that unsatisfactory income support, housing support, disability support and cultural services will significantly increase the likelihood of mental illness developing or worsening' and that '(w)ithout a sufficiently supportive social security net, mental illness will stagnate or deteriorate, which will then push people into behaviours and choices that result in criminalisation.' During the hearings for this inquiry in Kingaroy on 20 April 2022, the committee heard powerful evidence from the South Burnett CTC about the impact of socioeconomic disadvantage on mental health, and the impact of intergenerational trauma in places like Cherbourg.

The report's recommendations to address this include the housing factors mentioned above, employment opportunities for people experiencing mental ill-health and alcohol and other drugs issues (Rec 16), wellbeing strategies for CALD communities (Rec 11) and LGBTI communities (Rec 12), and the development of a broader Mental Health and Wellbeing Strategy (Rec 19). In an effort to address poverty, this wellbeing strategy should include:

- Advocating to the Federal Government to raise the rates of Federal payments, including JobSeeker, DSP, the Age pension and rent support.
- Free public transport at the state level.
- Free childcare.
- Eliminating costs and fees at state schools, and fully funding state schools.
- Increasing funding to neighborhood centers.

Recommendation 5: Improve access to secure and affordable housing in Queensland via public housing, rent caps and long-term leases, alongside measures such as free public transport, fully funding state schools and eliminating school fees, increasing funding for neighbourhood centres and advocating to the Australian Government for free childcare and increased income support payments, including raising the rate of JobSeeker, the Disability Support Pension, the Age Pension and rent support.

Prevention

Linked to the social determinants of health, there is scope for further recommendations regarding prevention, both at systemic levels and targeted for groups and individuals.

Eating Disorders Queensland, for example, talked about the need for systemic change to diet and weight loss culture to address eating disorders. Women's Health & Equality Queensland talked about schools-based programs to support young women's self-esteem and self-image, and suggested that mental wellbeing be a priority as part of a Queensland Women's Strategy. The Queensland Mental Health Commissioner talked about the benefits of school-based early interventions, and stressed the critical need that has emerged with regards to youth mental health.

Recommendations should include:

- Providing funding for prevention programs regarding mental health, eating disorders, AOD and support for LGBTI people, including school-based programs and community-based programs. The wellbeing workforce being rolled out in schools is a good start, and there is scope to conceptualise schools as health and wellbeing hubs, with access to GPs, psychologists, other healthcare professionals, and specialist prevention services, using models developed in the US and elsewhere.
- A 'no wrong door' approaches at hospitals and other support settings to assist people with dual diagnoses
- Support via other community organizations such as sporting clubs and community hubs.

Recommendation 6: the Queensland Government should invest in programs which work on preventing the root causes of mental illness, including school- and community-based programs.

Conclusion

In a state as wealthy as Queensland, there is no excuse for an underfunded and ill-equipped mental health system. With an evidence base as detailed as what this inquiry has heard, as well as experiences interstate and overseas, there is no question about what is involved.

As we recover from the COVID-19 pandemic and move towards high-profile state events such as the 2032 Olympic games, now is the time to invest properly in our social infrastructure. If we do so, this investment will pay dividends for years to come. But without meeting the needs of the mental health system right now, we risk incalculable costs to our community in the future.

I look forward to working with all members of parliament to implement the recommendations of the report.

Dr Amy MacMahon
MP for South Brisbane

STATEMENT OF RESERVATION

We acknowledge that the response to problems throughout the Mental Health, Alcohol and Other Drugs sectors are complex. The impact of mental illness on the Queensland community cannot be understated. It is a significant issue in society which demands our attention. The consideration and implementation of Recommendations 2 to 57 included in this report will go some way to addressing this very complicated issue in how we best prevent, and care for those with mental illness.

It should be clear, as Opposition members of the Committee, we wish to convey our broad support for recommendations 2 to 57.

We want to see exceptional care delivered for those Queenslanders with mental illness. We want to engage, empower and grow our Mental Health workforce. We want to learn from and implement new service models which have worked domestically and internationally. We agree with the government on those things.

We hold serious reservations with the way the Palaszczuk Government plans to raise a new revenue stream.

It is for this reason that we hold serious reservations with Recommendation 1.

Clearly the government is planning to rollout a new tax on Queenslanders. Specifically, we are concerned that this would be in the form of a new payroll tax.

It is firmly our view that a new tax on payroll is not the answer.

Properly funding and resourcing the Mental Health Sector is critical however, introducing a new payroll tax would force small, medium and large business to pass on their costs to Queenslanders.

Every Queenslander will be pay for this tax.

It would increase the cost of everyday goods and services.

At a time when cost of living pressures are skyrocketing, electricity prices are soaring and interest rates are set to climb, Queenslanders can't afford any more financial pressure.

Queensland household budgets are already extremely tight – another tax would tip many over the edge.

Many Queenslanders are currently choosing whether to pay bills or put food on the table.

We find it extraordinary that while this is happening the Palaszczuk Government would consider introducing a new tax.

It is our view that the funds required to properly resource the Mental Health Sector can be raised from existing revenue without the need to cut services or staff.

To be clear, this means the funds should be sourced from the existing budget and not come at the cost of public service jobs or services.

Queenslanders are seeing an extraordinary level of waste by this government. Chronic cost blowouts on infrastructure projects now run into the billions of dollars¸ Queenslanders have seen the wasted money on IT projects that never got off the ground and as well as the

politically driven decision to build a taxpayer funded quarantine facility that has barely been used and we will never own.

In no way should Queenslanders currently facing rising cost of living pressures be made to pick up the bill for the Palaszczuk Government's failure to manage its own budget and public projects.

The work of the Committee has been extensive, and thorough. The spirit of bipartisanship throughout the Inquiry has been necessary and welcomed.

However, this recommendation degrades and cheapens the entire Parliamentary Inquiry which we have just participated in.

It is now obvious that this recommendation was set in stone before the Inquiry was even announced by the Minister for Health and Ambulance Services.

When it comes to issues across the broader health system, the Premier, and the Minister for Health and Ambulance Services, have developed a legitimate reputation of blaming others for the failures of the system which they run.

Now, not only are the Premier and the Minister blaming others for these problems, they are expecting Queenslanders to pay for their problems too.

For the government to launch this Inquiry and turn the sensitive issue of mental illness into a trojan horse to raise revenue through a payroll tax is inexplicable.

The solution to tax Queenslanders in the middle of a cost of living crisis would exacerbate the very problem this Committee sought to solve.

Queenslanders are already under enough pressure, a new tax would only make things tougher in difficult times.

A good government would acknowledge this.

A good government would acknowledge the very real impact that mental illness has on Queensland's social fabric and the productivity of our economy.

A good government would accept responsibility for its own failures, seize on emerging treatments and models of care, and chart a path to address the problems at hand.

And, a good government would take the appropriate steps to identify waste, prioritise its spending, and responsibly fund the sector to the level which is required.

Yet, here in Queensland, that style of government is now totally absent.

We agree that swift action is necessary.

We also acknowledge that the prevalence and nature of mental health issues have worsened over the past two decades. There is no doubt that this is the case.

However, imposing a payroll tax which will be passed on to all Queenslander's is not the way to address this critical issue. Our Mental Health, and Alcohol and Other Drug sector can be appropriately funded if the government chose to prioritise its funding from existing sources.

We put forward this view throughout the Committee's deliberations. Sadly, it has been ignored.

The Committee has heard deeply personal, harrowing stories. They are stories of unimaginable tragedy and heartache.

Likewise, the Committee has heard experiences and examples, of hope and strength. Where with the right care, at the right time, Queenslanders have beaten back the darkness to beat mental illness.

It can be done, and as elected representatives we must enable this to occur.

We have also heard from the incredible people who work throughout the sector. They are to be commended for their tireless efforts in preventing and treating mental illness.

The Opposition would like to sincerely thank all those individual Queenslanders, and organisations, who took the time to attend public hearings, or contribute by way of written submission to the Committee.

We owe it to all of them and every Queenslander to properly resource our strained Mental Health Sector in a way that will genuinely achieve the broad scale improvements we all desire.

Rob Molhoek MP

Deputy Chair

Dr Christian Rowan MP

Amanda Camm MP