Queensland Alliance for Mental Health

General Foundational Supports – QAMH Submission

December 2024

Who is QAMH?

The Queensland Alliance for Mental Health (QAMH) is the peak body for the Community Mental Health and Wellbeing Sector and people with experiences of psychosocial disability in Queensland. We represent more than 100 organisations and stakeholders involved in the delivery of community mental health and wellbeing services across the state. Our role is to reform, promote and drive community mental health and wellbeing service delivery for all Queenslanders, through our influence and collaboration with our members and strategic partners. We provide information about services, work to build community awareness, education and training to influence attitudes and remove barriers to inclusion and advise government on issues affecting people with experiences of psychosocial challenges. At a national level, we have a formal collaboration with Community Mental Health Australia and provide input and advice to the work of Mental Health Australia and the National Mental Health Commission where appropriate. Locally, we work alongside our members, government, the Queensland Mental Health Commission and other stakeholders to add value to the sector and act as a strong advocate on issues that impact their operations in Queensland communities.

QAMH contact details

For any further information please contact:

Chloe Jesson

Director Operations

109 Logan Road, Woolloongabba QLD 4102

Email: cjesson@qamh.org.au
Tel: (07) 3555 6850

Acknowledgement of Country

QAMH acknowledges the Traditional Custodians of the land on which we live, learn, and work and recognises their continuing connection to land, waters and community. We pay our respects to them and their cultures; and to Elders past, present and emerging.

Recognition of Lived Experience

QAMH recognises that the Community Mental Health and Wellbeing Sector exists because of people with Lived Experience of mental distress, their families, carers and support people. We acknowledge the expertise and the courage of people with Lived Experience, and we commit to work with and alongside people with Lived Experience in all we do.

Key Messages

- A five-year plan to increase investment in psychosocial supports outside the NDIS must be agreed by Commonwealth, State and Territory governments as a matter of priority to address the critical gap in supports for people experiencing moderate to severe mental illness.
- Foundational Supports should utilise Principles for Foundational Supports (*see Box 1*) and include a mix of:
    - **Wellbeing Connectors**: place-based navigator support based on social prescribing that helps people to identify their wellbeing goals and develop a plan to meet those needs. Wellbeing Connectors should be wellbeing focused, not illness or disability focused. They should utilise trauma-informed approaches and aim to develop individual, family and community capacity.
    - **Community-based groups and activities:** diverse local networks of funded capacity-building peer support groups and social prescribing activities that people can be linked into, depending on their needs and wellbeing goals.
    - **Targeted Psychosocial Supports**: one-to-one, practical, person-led supports that create opportunities for people to better respond to their needs, such as social connection, relationships, self-care and economic participation. Psychosocial support workers may draw upon their own personal life-changing journey of mental health challenges, service use and recovery to coach others on their recovery if working in lived-living experience peer worker roles. They also enable carers, family and kin to participate in employment and engage with the community.
- First Nations communities must have sovereignty over the design and delivery of supports, recognising their right to self-determination and ensuring culturally safe and appropriate services that align with cultural protocols and community priorities.
- Outreach supports and innovative service delivery models should be co-designed with vulnerable hard to reach groups, including People with Multicultural and Diverse Backgrounds and Connections, and mental health carers.
- Funding models must include adequate pricing for regional supports, training and supervision, governance, risk management and quality assurance processes. They should also seek to co-design outcomes measures upfront, enable flexibility in service delivery, and incorporate brokerage funding to encourage holistic and innovative approaches to wellbeing.
- The needs of individuals accessing support for multiple disabilities across the ecosystem need to be considered to ensure that they are not unfairly disadvantaged by the system.
- Workforce challenges and opportunities should be addressed as a priority to ensure that we are able to meet sector capacity needs.

Box 1: Principles for Foundational Supports

Foundational Supports should:

- Draw on "community" at the heart of their work providing opportunities for people to re-engage with their relationships and natural community, reducing social isolation and loneliness – key determinants for mental wellbeing.
- Uphold UNCRPD and human rights approach which values least restrictive practice and operates from a social justice framework, that can empower individuals and communities to change structural inequalities.
- Be well-resourced, locally co-designed services that encourage innovation, respond to local needs and maximise local strengths, resources and networks.
- Apply a social model of disability, that encourages accountability within the system for service models that systemically contribute to disability, rather than address disability barriers.
- Include a mix of place-based and outreach services.
- Enable a wide range of referral pathways, including self-referral.
- Not apply strict time limits.
- Have a strong focus on social prescribing.
- Be wellbeing-focused, not illness or disability-focused.
- Have broad and simple eligibility criteria and access processes.
- Be easy to enter / exit / re-enter as required.
- Have no cost to access.
- Enable choice in who people work with.
- Utilise individual and community capacity building approaches to general supports, with prevention and recovery focused targeted psychosocial supports.
- Be provided in naturally occurring places in the community.
- Include a wide range of service options that are tailored to First Nations Australians, multicultural and other diverse groups e.g. LGBTIQA+.
- Be provided by skilled staff with access to quality training and supervision.
- Embed lived experienced voices in program design, delivery and evaluation so that codesign and coproduction with people with lived experience is the benchmark.
- Use trauma-informed skills and knowledge when working with all people with disability.
- Provide a whole-of-life approach that enables people to navigate and respond to their broader needs including housing, employment, legal issues, family support and alcohol and drug challenges.

Responses to consultation questions

Is the broad focus and scope of information advice and capacity building supports aligned to what you would expect? Are there any gaps?

It is widely acknowledged that there are vast inequities in support for people outside the National Disability Insurance Scheme (NDIS). The recent public release of the national Analysis of Unmet Need for Psychosocial Support Outside the NDIS highlights just how immense the problem is: 230,500 people with severe mental illness and 263,100 people with moderate mental illness are not receiving the psychosocial support they need according to data from 2022-2023[1]. This number far exceeds previous estimates of 154,000 from the Productivity Commission in 2020, and magnifies the urgent need for fully funded, high quality services that can meet the scale of this challenge. QAMH has been a vocal advocate for the need to address this extensive gap in psychosocial support.

Crucially however, the Unmet Needs Analysis estimates unmet need for psychosocial supports outside the NDIS based on *current levels of NDIS psychosocial support provision*. QAMH is concerned that recent changes to NDIS legislation could effectively exclude an additional 101,036 Australians[2] who have severe, chronic, and complex psychosocial disability needs and who currently access NDIS support for psychosocial disability, as either a primary or secondary disability. This is a total of 594,636 Australians who will potentially be without support until a properly designed and funded system is in place.

It is critical that we get these changes right.

The Department of Social Services is conducting this consultation process without allowing stakeholders to consider how key elements of the system function together in an integrated way. Discussion of Targeted Psychosocial Supports – a key recommendation of the NDIS review – and the NDIS Early Intervention Pathway are conspicuously absent from this consultation, despite being crucial to the conversation to avoid unnecessary duplications and critical gaps for people with disability. We reiterate that without broad and adequate access

[1] Health Policy Analysis. (2024). *Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme*. Accessed online 19/08/2024 at Final Report - Analysis of unmet need for psychosocial supports outside of the National Disability Insurance Scheme (health.gov.au)

[2] National Disability Insurance Scheme. (2024) *Participant datasets*. https://dataresearch.ndis.gov.au/datasets/participant-datasets

to the right support at the right time, not only will people with psychosocial disability be potentially worse off, but unpaid carers – including young carers[3] – will again be left to fill the gap in psychosocial supports, perpetuating, and reinforcing the current issues of mental ill health facing our communities.

There is plenty of work ahead before governments can adequately respond to this gap, including a renegotiation of the National Health Reform Agreement, the National Mental Health and Suicide Prevention Agreement and Bilateral Agreements between the Commonwealth and states and territories on the NDIS. QAMH support Mental Health Australia's recommendations that continuity of existing federally-funded psychosocial supports – both via the NDIS and via the Commonwealth Psychosocial Support Program - must be maintained until this work is done. Unless the Government sends a very clear message to reassure people with psychosocial disability, the community, and the sector that there is a clear plan for investment in psychosocial supports, there is a risk that we allow sector collapse and the loss of a skilled and critical workforce due to the uncertainty providers face in this transition period.

What could support innovation, quality and best practice in the delivery of General Supports for information, advice, referral and capacity building?

A well-resourced ecosystem of supports, based on social prescribing

QAMH believe that there is a significant opportunity to develop a wellbeing focused ecosystem of support – with navigator support based on social prescribing - to meet information, advice, referral and capacity building needs for all people with foundational support needs. We believe that these supports are required *in addition to* targeted psychosocial supports for people experiencing moderate to severe functional impacts due to mental illness. It also requires a well-resourced network of support groups and activities for people to be referred into, tailored to the needs of local communities.

Figure One (page 7) provides a visual representation of what this ecosystem could look like, with a focus on psychosocial support needs. Key elements of this model are explained in Table One (page 8).

[3] Arafmi. (2024). *At What Cost? The Experiences of Unpaid Mental Health Carers in Queensland 2023-2024.* Available at A04-Arafmi-At_what_cost_040624-web.pdf

Figure 1: Ecosystem of Support

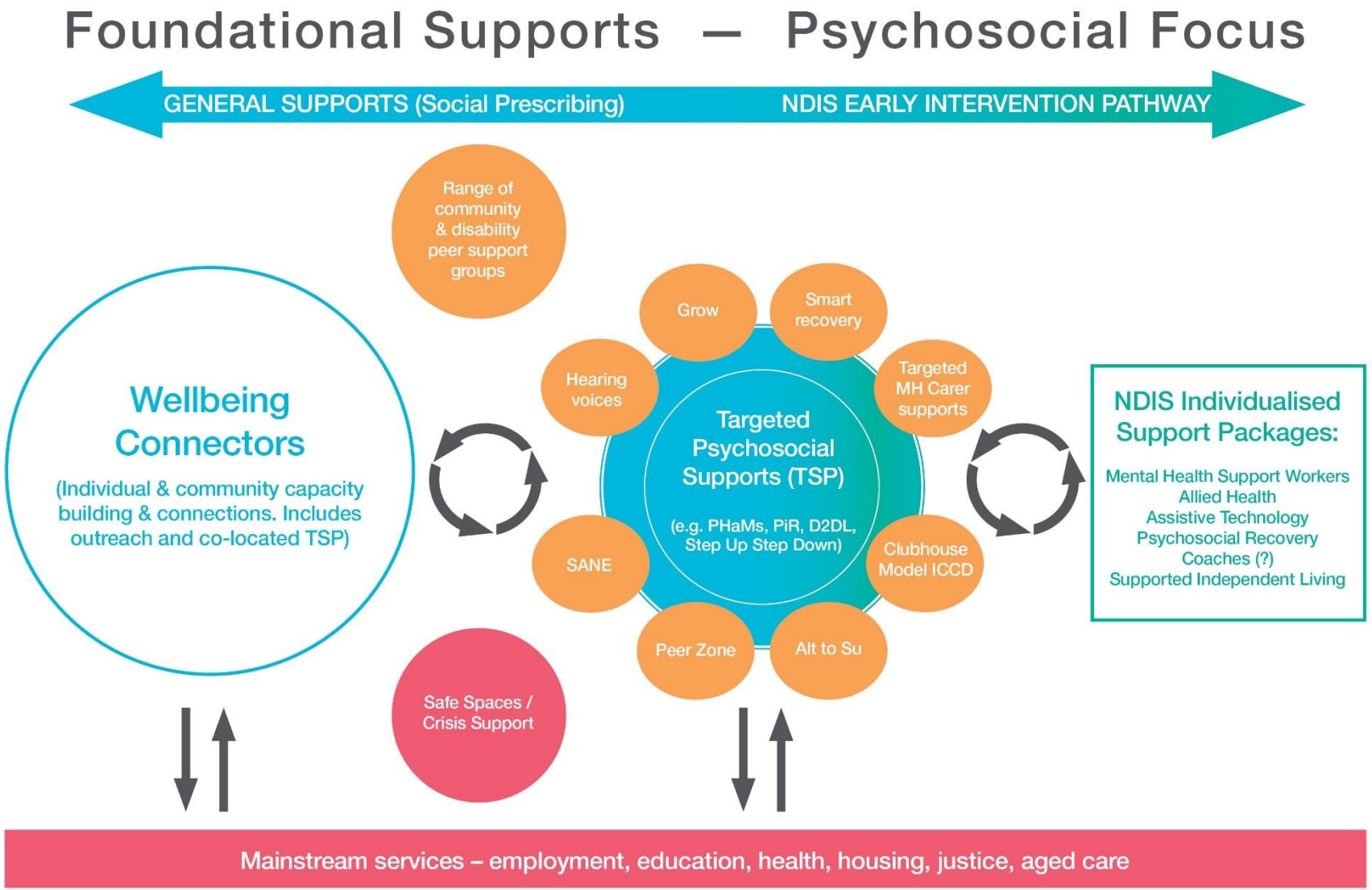

Table 1: Key Elements of Foundational Supports and Early Intervention Ecosystem

Wellbeing Connectors	Place-based social prescribing (navigator) support that helps people to identify their wellbeing goals and develop a plan to meet those needs. Wellbeing Connectors should be wellbeing focused, not illness or disability focused. They should utilise trauma-informed approaches and aim to develop individual, family and community capacity.
Community-based groups and activities	Diverse local networks of funded capacity building peer support groups and social prescribing activities that individuals and families can be linked into, depending on their needs and wellbeing goals.
Targeted Psychosocial Supports	One-to-one practical, person led supports that create opportunities for people to better respond to their needs, such as social connection, relationships, self-care and economic participation. Psychosocial support workers may draw upon their own personal life-changing journey of mental health challenges, service use and recovery to coach others on their recovery if working in lived-living experience peer worker roles. They also enable carers, family and kin to participate in employment and engage with the community.
NDIS Early Intervention Supports	Tailored packages of supports that can be purchased using NDIS individualised funding, such as Mental Health Support Workers, Allied Health, Assistive Technology, Psychosocial Recovery Coaching and Supported Independent Living.

Social prescribing is an innovative practice that aims to improve overall wellbeing in non-medical ways. It is an early intervention support model that QAMH believe has potential to meet the system navigation and foundational support needs of people, before they progress to long-term mental ill-health or permanent disability. Importantly, it also provides a referral point for GPs, healthcare workers and other mainstream services to refer people into for support. In the model that we are proposing, QAMH recommend that "Wellbeing Connectors" are funded to:

- work with individuals and families to co-design their personal wellbeing plans and link people (via warm handover if required) to services and supports that build their capacity to address wellbeing needs and social determinants;

- develop the capacity of individuals and families to connect with each other to develop peer-led advocacy groups and networks as part of their "Connector" role;
- engage with mainstream services to improve their ability to be inclusive and responsive to the needs of people with disability.

While these functions generally reflect the broad description of "Navigator" roles proposed by the NDIS Review, QAMH suggest that "Wellbeing Connector" is a better term to reflect the skills, values and attitudes that should underpin the role. We believe (and have heard in consultations) that "Navigator" implies an expert-led approach, rather than the person-led approach that is required to put people with disability at the centre of their support. A community development and capacity building approach are key features of the Wellbeing Connector role. Wellbeing Connectors will also need to have skills in person-led support and trauma informed practice. These are areas in which the Community Mental Health and Wellbeing workforce holds significant expertise and capability.

Underpinning the effectiveness of this model is the development of a complementary network of funded community-based groups and activities that build peoples capacity to address wellbeing needs. Ideally, this "ecosystem of supports" should be co-designed with local communities to ensure the appropriate mix of supports and activities to meet local needs. Care should be taken to draw on local strengths and resources and ensure support is provided in naturally occurring places in the community, as per Principles for Foundational Supports, listed in Box 1.

Although social prescribing is yet to be widely adopted in Australia, it is included in Australia's National Preventive Health Strategy 2021–2030[4] and Primary Health Care 10 Year Plan 2022–2032[5]. It also aligns with Measuring What Matters, Australia's national wellbeing framework that aims to guide policy and decision making towards a more healthy, secure, sustainable, cohesive and prosperous Australia. Social prescribing has been attracting increasing attention both in Australia and internationally as an evidence-based, affordable, and complimentary solution to more conventional treatments such as prescription medications and referrals to

[4] Commonwealth of Australia. (2021). *National Preventive Health Strategy 2021-2030*.
[5] Commonwealth of Australia. (2022). *Future Focused Primary Health Care: Australia's Primary Health Care 10 Year Plan 2022-23*.

psychologists (see for example [6] [7] [8] [9]). Social prescribing via a community link worker reduces pressure on acute health systems and has been shown to be a cost-effective approach with significant social return[10]. A recent 2024 evaluation of social prescribing outcomes across nine local health systems in England found:

1. a 42 percent reduction in GP appointments
2. a 23 percent in emergency department attendances
3. a nine percent decrease in secondary care costs
4. up to a 39 percent cost reduction for frequent emergency department users[11].

These benefits extend across a wide variety of cohorts, contexts and settings, including people with disability. A review of Australian link worker social prescribing programs has recently recommended that policy makers and funders explore social prescribing across funding models in Australia, including NDIS[12].

Social prescribing has also been recently shown to hold promise in improving health outcomes in rural Australia[13]. However here, the research suggests that there is a need to focus on developing scalable, tailored social prescribing models for rural communities[14]. We

---

[6] World Health Organisation. (2014). *Social Determinants of Mental Health*. Available at https://iris.who.int/bitstream/handle/10665/112828/9789241506809_eng.pdf?sequence=1

[7] Community Support and Services Committee. (2021). *Inquiry into Social Isolation and Loneliness in Queensland: Report No. 14, 57th Parliament Community Support and Services Committee*.

[8] Fancourt D, Finn S. (2019). *What is the evidence on the role of the arts in improving health and well-being? A scoping review*. Copenhagen: WHO Regional Office for Europe.

[9] Dingle, G. (2023). *Report on the 18-Month Evaluation of Social Prescribing in Queensland*. Available at https://www.researchgate.net/publication/373653337_Report_on_the_18-month_evaluation_of_social_prescribing_in_Queensland_2

[10] O'Connell Francischetto, E., Bradly, J. and Knight K. (2024). *The Impact of Social Prescribing on Health Service Use and Costs: Examples of Local Evaluations in Practice*. Available at The Impact of Social Prescribing on Health Service Use and Costs- Examples of Local Evaluations in Practice – Social Prescribing Tools and Resources

[11] O'Connell Francischetto, E., Bradly, J. and Knight K. (2024). *The Impact of Social Prescribing on Health Service Use and Costs: Examples of Local Evaluations in Practice*. Available at The Impact of Social Prescribing on Health Service Use and Costs- Examples of Local Evaluations in Practice – Social Prescribing Tools and Resources

[12] Baker JR, Bissett M, Freak-Poli R, Dingle GA, Zurynski Y, Astell-Burt T, et al. (2024) *Australian Link Worker Social Prescribing Programs: An integrative review*. PLoS ONE 19(11): e0309783. Available at https://doi.org/10.1371/journal.pone.0309783

[13] Saddiq, I., Simmons, P. and Osuagwu, U.L., (2024). *Social Prescribing in Rural Australia: A Mapping Review of Benefits, Challenges, and Implementation Strategies*. Available at https://ssrn.com/abstract=5003949

[14] Saddiq, I., Simmons, P. and Osuagwu, U.L., (2024). *Social Prescribing in Rural Australia: A Mapping Review of Benefits, Challenges, and Implementation Strategies*. Available at https://ssrn.com/abstract=5003949

recommend that the Government works with Primary Health Networks and other relevant stakeholders to provide further funding to explore new community-based social prescribing models in communities across regional and rural Queensland. In these areas, access to community-based resources can be limited and it is likely that such areas will need alternative, bespoke models of social prescribing to ensure effectiveness for those communities, rather than a one size fits all approach. We believe that encouraging communities to consider their own naturally occurring community resources and identifying what is needed or missing so that they can co-design a model suited to their own local context will be a key design feature of a successful social prescribing scheme for Foundational Supports.

Adopt best practice "Principles for Foundational Supports" to guide funding, policy and service delivery decisions

Investing in inclusive, rights-based supports creates a healthier, more productive society where people with all disabilities, including psychosocial disability, contribute to the workforce and enrich cultural and social life. QAMH recommends that governments adopt the best practice Principles for Foundational Supports listed in Box One (page 4) to guide funding, policy and service delivery decisions regarding Foundational Supports.

These Principles were developed by QAMH and adopted by the Queensland Disability Peak Network in its submission Queensland Disability Reform Foundational Supports design concepts for consideration to guide development of the Queensland Disability Reform Framework. The Principles are based on Wellbeing First principles and reflect considerable consultation that QAMH and the Queensland Psychosocial Peak Body (PPB) have undertaken in this area to include the voices of people with psychosocial disability in policy discussions.

Since 2022, our consultations with people with lived-living experience have consistently identified common key themes, such as the need for better access to community-based support, social inclusion, peer engagement, holistic approaches and the integration of support services. In July 2024, QAMH and the Queensland Psychosocial Peak Body conducted the Psychosocial Supports Deep Dive Consultations to build on these findings and engage individuals with lived-living experience to specifically explore how elements of Foundational Supports can be effective for those experiencing psychosocial disability in Queensland. The consultations served three main objectives:

- engaging the Lived and/or Living Experience community in Foundational Supports discussions;
- contributing to the evidence base for advocacy; and
- increasing the PPB's connection with the lived experience community across Queensland.

Focus groups consultations were held in Caboolture and Townsville to capture metropolitan and regional perspectives. While efforts were made to recruit participants from First Nations communities and culturally diverse backgrounds, this was hindered by time constraints.

The following key themes emerged from the PPB Psychosocial Supports Deep Dive Consultations that are applicable to the design of General Supports:

- **Connecting with Supports:** Participants emphasised the need for supports to be available to anyone at any time, without barriers, such as cost or needing a referral or diagnosis. Participants highlighted the importance of meeting in safe, welcoming environments chosen by the consumer. For participants in Townsville, greater availability of services in general was a particular issue, including access to 24 hour supports.
- **Features of Supports:** Participants emphasised that supports for people with psychosocial disability should take a holistic approach, tailored to individual's needs. There was a strong feeling that individuals should have the choice to select their own 'Navigator' based on rapport and shared worldview. Key qualities for workers included being trauma-informed, empathetic, non-judgmental, and having good communication skills. There was some overlap in terms of what people felt that 'navigators' and foundational psychosocial support services should "do", including providing practical support, helping to find opportunities to connect with others and access services, and providing capacity building support to manage emotions and learn new skills. Participants stressed the value of lived experience among workers, the importance of being able to choose who they work with and meeting people where they feel safe and comfortable.
- **Digital Support Services:** Participants recognised the benefits of digital support services, such as immediate access and self-empowerment. They suggested applications for online peer support, game technology for wellbeing goals, narrative-based AI counseling, mindfulness promotion, and connecting with wellness activities. However, participants had a clear preference for human-led digital support over purely digital navigation support.

A full report on the Psychosocial Supports Deep Dive Consultations is available on the QAMH website. The findings in this report support our recommendations regarding the design of the ecosystem of support and best practice Principles for Foundational Supports.

Ensure that Foundational Supports meet the needs of diverse groups

QAMH is currently also partnering with Community Mental Health Australia and Mental Health Coalition of South Australia to explore effective service models for groups with varying needs, intersectionality and access considerations, via the next round of the Assisting

Communities Through Direct Connection (ACDC) Project. While this research is due for completion May 2025, early findings are included in our response below.

The ACDC project is a joint initiative of Community Mental Health Australia and The Centre for Social Impact, funded by the Department of Social Services. Between 2021-2024, the project knocked on 52,594 doors and held 9,287 in-depth conversations with householders, providing extensive data on the mental health and wellbeing needs in communities across Australia[15].

The project findings highlight significant disparities in access to mental health support and mental health outcomes for certain groups. Factors like being born outside of Australia, speaking a language other than English, employment status, and living in outer regional areas impacted access to mental health support. Overall, a large proportion of respondents were found to be experiencing distress and sought, but did not receive, mental health support. Approximately 49.4 percent of respondents reported moderate to very high distress, with 36.7 percent stating they needed more support[16]. Alarmingly, 43.2 percent of those who wanted help in the last year did not receive it. About a quarter (25.6 percent) could not afford the cost of the service/support, 23.7 percent did not know where to go to get help, and 22.3 percent said they were too afraid, embarrassed or ashamed to ask for help. Social determinant factors such as housing, employment challenges, and financial stress, also correlated with higher levels of distress and lower wellbeing scores.

Overall, the project findings show that we need to consider broader causes of mental distress such as social inequality, poverty, and lack of affordable housing. It is important to provide holistic support that addresses both mental and emotional wellbeing and social equity needs. The design and delivery of mental health support are crucial, as people may face barriers to accessing appropriate help. In particular, the findings highlight that connecting with vulnerable groups through outreach models, establishing trust, a problem-solving approach, and addressing access barriers are necessary. Proactive outreach, like doorknocking, can effectively reach those in need, especially in lower socio-economic suburbs. Providing support by health professionals or peer support, as well as information about local mental health services, is essential. Additionally, allocating funds to eliminate out-of-pocket costs for mental health care can support prevention and early intervention efforts.

---

[15] Kaleveld, L. Szabo, L. and Hooper, Y. (2024). *Door-to-Door for Mental Health: A summary report. Research and Evaluation Findings for the Assisting Communities through Direct Connection Project, Round Three*. Available at ACDC-Summary-Report-2024-2.pdf

[16] ACDC. (2024). *About the ACDC Project*. Available at About The ACDC Project - ACDC

The ACDC Project highlighted specific findings for cohorts identified in Table Two below.

Table 2: Mental Health and Wellbeing Considerations for Specific Cohorts - ACDC Project Findings

First Nations Communities	• The rates of people in very high distress are much higher in First Nations communities - close to four in 10 (37.3%) Householders were in high or very high distress, however one in four Aboriginal and/or Torres Strait Islander peoples in the ACDC sample were experiencing very high psychological distress (25.2%).
CALD Communities	• Particularly appreciative of and responsive to the door knocking outreach approach to support. • There are health inequalities for immigrants without a visa, who are unable to connect with a service • CaLD communities were found to sometimes have complicated experiences of mental health. This is often the result of a confluence of factors involving family expectations, cultural obligations, and cultural understandings around mental health, resulting in less inclination and a lack of 'permission' to seek support for mental health and wellbeing. • Of Householders who identified as being part of CALD, 37.5% faced language barriers. This impacted their awareness of supports and abilities to access and apply for services for themselves or their loved one – which often meant that family members and carers went unsupported themselves, as well as being left with the full burden of supporting their family member or loved one. • For those aware of the support suggested by People Connectors but who had experienced difficulty accessing support, reasons for this included the inability to understand or navigate service information (especially for those with website-based applications), long in-take processes or wait times, and strict eligibility requirements.

	• There are multiple barriers to connection including scarcity mindsets, cultural stigma surrounding mental health (pride and shame) and being self-reliant or only relying on family, language barriers, as well as physical, mental, and social barriers. • People born outside of Australia, and/or who spoke a language other than English at home, were less connected to mental health supports despite a mental health need.
People with Disability	• People with disability reported significantly higher distress scores (K10; p<.001) and significantly higher loneliness scores (p<.001) however they were also better connected to mental health supports. • Of the Householders with disability (n = 219), only a quarter were receiving support from the NDIS. • 20.8% (n = 219) of householders reported having a disability. Of these respondents, 25.5% (n = 54) were receiving support through the National Disability Insurance Scheme (NDIS). For those not receiving support, 22.4% (n = 33) had attempted to seek support through the NDIS. • Lack of access to appropriate, effective NDIS services was identified by ACDC. Poor wellbeing was exacerbated by being rejected by the NDIS scheme. For others who were engaged with the NDIS, they felt unsupported, distressed, and invalidated by their experience with the scheme.
Older People	• Particularly appreciative of the outreach door knocking approach to support. • For the cohort of Householders who were elderly, 56% experienced significant difficulties with carrying out domestic duties and maintaining their home to a safe, acceptable standard, and 55% of Householders also faced transport issues within their community, were elders. Notably, issues with transport in the community led to social isolation. While Householders may have been aware of aged care services focusing on health concerns, linking to more practical supports

	and social supports was found to be an unmet need in older Householders across the Project Sites. • There are gaps in systemic processes (e.g. hospital discharge planning) that can put older people at risk.
Carers	• Particularly appreciative of the door knocking approach to support. This may be particularly the case for CALD carers. • 23.2% of respondents reported they were a carer/support to someone with disability, a chronic condition, or mental health concern. • It was found that 25% of the 'high-risk' Impact Stories where people had multiple unmet needs involved Householders who were family members providing care. As such, doorknocking identified carers has having significant challenges – particularly, the hardships with recognising that their own needs and seeking help for their own mental wellbeing, often due to their caring role being overwhelming and all encompassing. The project found that people may not recognise that they're a family carer.
LGBTQIA+	• The sample of people in the LGBTQIA+ community in the ACDC project was very low (n = 27), however this group seemed to be much less connected to only a community support only, compared to those who did not identify as LGBTQIA+.
People who are Employed	• Those who were employed, and experiencing a mental health need, were significantly less connected to mental health supports compared to those who reported being unemployed or not in the labour force. They may be looking for support for the first time, however unsure whether their "need" is great enough. Those not in the labour force were the most connected to supports. • As employment satisfaction decreased, distress (K10 and K5) significantly increased (<0.05) and, as employment satisfaction increased, wellbeing (WHO-5) significantly increased (<0.05).

Reformed funding models

QAMH welcomes the move to block funding for Foundational Supports. We believe this has the capacity to better accommodate quality provision of complex supports than the current Disability Support Worker Cost Model (DSWCM). The DSWCM applies severely limiting cost assumptions that are plaguing NDIS pricing and the fee-for-service model, causing most NDIS providers – particularly those providing complex supports - to experience serious viability concerns[17]. However, we also believe grant-based funding models require significant review and reform to effectively support innovation, quality and best practice in the delivery of Foundational Supports. We have previously outlined our recommendations to the Department of Social Services in our submission to the consultation process for *A Stronger More Diverse and Independent Community Sector*.

In our submission, we highlight that funding models must include adequate pricing for regional supports, training and supervision, governance, risk management and quality assurance processes. They should also seek to co-design outcomes measures upfront, with less reliance on clinical measures such as K10, enable flexibility in service delivery, and incorporate brokerage funding to encourage holistic and innovative approaches to wellbeing.

What else needs to be considered?

Peoples experience across the system and the needs of people with multiple disabilities

QAMH is concerned that there is not enough attention currently being paid to the needs of people experiencing multiple disabilities, especially those who experience psychosocial disability in addition to other disability or disabilities. In particular, we are concerned that restrictions on eligibility for Targeted Psychosocial Supports and/or NDIS support (via either the Early Intervention or Disability pathways) will unfairly discriminate against and disadvantage people with psychosocial disability.

[17] The Ability Roundtable. (2023). *Ability Roundtable White Paper: Insights into financial and workforce performance of the disability support sector*. Available at Telling the Sector's Story - Ability Roundtable White Paper (2).pdf

As of December 2023, there were a total of 63,508 NDIS participants with psychosocial disability listed as their primary disability across Australia[18]. Data from the Australian Institute of Health and Welfare (AIHW) shows that in 2021, a further 34,200 people had psychosocial disability included on their NDIS plan as a secondary disability. These numbers are substantial. In addition, we know that people with disability experience high or very high levels of psychological distress at four times the rate of the general population[19].

QAMH has previously raised significant concerns regarding the proposed new planning processes and funding of NDIS plans for people with psychosocial disability. This includes that people with multiple disabilities will be unable to access support for impairments considered ineligible. Under the provisions of the new NDIS Act, it is less likely for psychosocial disability to meet the disability or Early Intervention criteria. Therefore, it is possible that many NDIS participants and providers may encounter situations where a person has dual physical and psychosocial disability, however is ***only*** able to access supports for physical disability via their NDIS plan, rather than support workers who also have mental health training and work for organisations that are properly set up to respond to participants with severe functional impacts due to mental illness.

Poorly considered eligibility criteria for Targeted Psychosocial Supports that restrict eligibility for NDIS participants could create a devastating situation for people with multiple disabilities. These participants may find themselves in situations where they are receiving inappropriate NDIS support that does not suit their mental health needs, but they are also not able to access support via Foundational Psychosocial Supports as eligibility criteria do not allow it.

Not only will this increase the already huge numbers of people not receiving support for moderate-severe mental illness identified in the Unmet Needs Analysis, it will also put many participants and providers in risky service delivery situations, or worse, result in situations where NDIS participants with severe levels of disability are unable to receive support *at all* for their listed disability because their needs are too complex for general providers.

---

[18] National Disability Insurance Scheme. (2024). *Explore Data – Participant Data*. Webpage available at https://data.ndis.gov.au/explore-data

[19] Australian Institute of Health and Welfare. (2023). *Health of People with Disability*. Webpage available at Health of people with disability - Australian Institute of Health and Welfare

Workforce and sector capacity challenges and opportunities

The Community Mental Health and Wellbeing Sector holds significant potential to deliver scalable, high-quality, evidence-based, and trauma-informed services. QAMH agree with Community Mental Health Australia that key to unlocking this potential is ensuring a well-resourced workforce that can work alongside Primary Health Networks (PHNs), community-based services, and other support systems to offer comprehensive, holistic care through approaches like social prescribing[20].

The QAMH Community Mental Health and Wellbeing Sector Workforce Strategy 2024-2029 aligns closely with the priorities outlined in the National Mental Health Workforce Strategy 2022-2032. Both strategies emphasise integrating community mental health services with Primary Healthcare as a crucial step to improving access, reducing stigma, and supporting long-term recovery. The Community Mental Health and Wellbeing Sector workforce is perfectly placed to be scaled up to meet need for Foundational Supports right across the ecosystem of support. To strengthen the Community Mental Health and Wellbeing workforce and meet this growing demand, the QAMH Workforce Strategy highlights three key pillars must be prioritised: Qualifications and Training, Attraction and Retention, and System Enablers. More information and recommendations relating to each of these pillars are contained within the full Strategy available on our website at the link above. However, QAMH support Community Mental Health Australia's recommendations for workforce development which are outlined in our recommendations below.

[20] Community Mental Health Australia. (2024). *NDIS General Supports Submission – Foundational Supports: Essential and overdue*. Unpublished.

Recommendations

Address the gap in psychosocial supports

- **Recommendation 1**: Put a clear plan in place to fund the gap in psychosocial supports. QAMH supports calls for a five-year plan to increase investment in psychosocial supports outside the NDIS to be agreed by the Commonwealth, State and Territory governments. This plan should be widely communicated to people with psychosocial disability, the community and the sector.
- **Recommendation 2**: The Australian government should extend current funding for Commonwealth psychosocial supports for another two years while governments develop future arrangements for psychosocial supports.
- **Recommendation 3**: The National Disability Insurance Agency should implement a freeze on all changes that affect NDIS plans for people with psychosocial disability, including proposed eligibility reassessments, until the five-year transition to Foundational Supports is complete.
- **Recommendation 4:** The Australian Government should release a clear timeline and thorough process for co-design and consultation on targeted psychosocial supports with people with lived-living experience of mental health challenges and psychosocial disability.

Foster innovation, quality and best practice in the delivery of foundational supports

- **Recommendation 5:** Develop a well-resourced system of supports, based on social prescribing.
- **Recommendation 6:** Adopt best practice Principles of Supports to guide the development of foundational supports and service delivery.
- **Recommendation 7:** Ensure First Nations communities have sovereignty over the design and delivery of supports, recognising their right to self-determination and ensuring culturally safe and appropriate services that align with cultural protocols and community priorities.
- **Recommendation 8:** Co-design outreach supports and innovative service delivery models with vulnerable hard to reach groups, including People with Multicultural and Diverse Backgrounds and Connections, and mental health carers.
- **Recommendation 9:** Review and reform grant funding models to include adequate pricing for regional supports, training and supervision, governance, risk management and quality assurance processes. They should also seek to co-design outcomes measures upfront, enable flexibility in service delivery, and incorporate brokerage funding to encourage holistic and innovative approaches to wellbeing.

- **Recommendation 10:** Ensure broad and simple eligibility and access processes are a key feature of all Foundational Supports elements and specifically consider the needs of individuals accessing support for multiple disabilities across the ecosystem to ensure that they are not unfairly disadvantaged by the system.

Address workforce challenges and opportunities

- **Recommendation 11:** Support Local Mental Health Services by ensuring Primary Health Networks (PHNs) are adequately resourced to fund community-based, trauma-informed, and recovery-oriented services that meet local needs and create a collaborative, sustainable workforce.
- **Recommendation 12:** Provide surety of funding by guaranteeing 5-year minimum contracts to stabilise and grow the workforce.
- **Recommendation 13:** Integrate Social Prescribing into the workforce to guide individuals toward holistic supports, addressing not only mental health but also social determinants such as housing, employment, and legal challenges. QAMH suggest that workers in these roles will require community development and capacity building skills and knowledge in addition to person-led support and trauma informed approaches.
- **Recommendation 14:** Implement a tailored approach for supports that recognises the social, demographic and cultural challenges of all communities.
- **Recommendation 15:** Embed lived-living leadership and Lived Experience Experts across the workforce. Peer workers and those with lived experience should be central to service delivery. Their involvement reduces stigma, builds trust, and enhances recovery-oriented practices.
- **Recommendation 16:** Prioritise a procurement strategy that preferences community-based, culturally safe service delivery and lived experience.