



Queensland Alliance for Mental Health

# Unleashing the Potential of the Health Workforce Submission

October 2023

## 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.

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### 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.

# Benefits of health professionals working to full scope of practice

## Background

QAMH welcomes the opportunity to provide input into the Unleashing the Potential of our Health Workforce – Scope of Practice Review (the Review). While we acknowledge this Review is primarily concerned with the clinical primary care workforce, QAMH believe that mobilising and integrating the Community Mental Health and Wellbeing Sector workforce to support primary care services holds significant potential to optimise the use of our nation’s scarce workforce resources, enhance the delivery of person-centred outcomes and address the mental health crisis that we are currently facing across the nation. We note that the National Mental Health Workforce Strategy has – to date – missed a significant opportunity to take advantage of the vast pool of specialised and complementary psychosocial supports represented by our Sector. This omission is confusing given the well documented gap of those missing out on psychosocial supports and the work currently underway to quantify that gap under the National Mental Health and Suicide Prevention Agreement [31].

Our submission offers achievable solutions, which will ease the burden on clinical primary care and provide more sustainable outcomes for those currently missing out on care. It outlines the case for change, to fundamentally redesign the mental health ecosystem to one that better supports the large cohort of people experiencing mild-moderate mental illness currently accessing primary care [5, 6, 7]. This will be done by effectively resourcing and expanding contracting through Primary Health Networks, and shifting to a new model of care that utilises social prescribing by Community Mental Health and Wellbeing Sector link workers, to complement primary care services and reduce demand on General Practitioners (GPs) and Allied Health practitioners. This shift will not only provide a much needed early intervention strategy, but free GPs and Allied Health Professionals up to effectively operate within their own scope of practice. Greater integration of primary care with other care systems is a key recommendation of the Strengthening Medicare Taskforce Report [1]:

*“Support local health system integration and person-centred care through Primary Health Networks (PHNs) working with Local Hospital Networks, local practices, ACCHOs, pharmacies and other partners to facilitate integration of specialist and hospital services with primary care, and integrate primary care with mental health, aged care, community and disability services.”*

QAMH has previously provided its vision for an integrated mental health system in its guiding document [Wellbeing First](#). We believe the Community Mental Health and Wellbeing Sector holds huge potential to transform the system through relatively easily scalable, high-quality, effective, evidence-based and trauma-informed services that consumers may perceive as being more psychologically safe to engage with than conventional responses [2, 9, 10]. We argue that properly resourcing Primary Health Networks to purchase these services locally, and integrating Community Mental Health and

Wellbeing Sector services with primary care through social prescribing, holds the key to maximising workforce resources, improving access and achieving better outcomes for all, including consumers, funders, mental health carers, health practitioners, employers, and government/s.

## **What is the Community Mental Health and Wellbeing Sector?**

The Community Mental Health and Wellbeing Sector includes non-government, not-for-profit, community-based mental health organisations that offer practical supports, provide opportunities to re-establish skills and relationships, help people connect with their communities, and address the social determinants of mental health. The sector also focuses on early intervention and prevention by removing barriers to wellbeing. Also known as psychosocial support, this approach offers a valuable point of difference to the clinical system and can work in a complimentary way to enhance the suite of services offered at the primary care end.

Workers in the Community Mental Health and Wellbeing Sector may be referred to in various ways, including Psychosocial Support Workers, Community Link Workers, Wellbeing Support Workers, Peer Support Workers, amongst other terms. For simplicity, in this paper we mainly refer to workers in the Community Mental Health and Wellbeing Sector as Psychosocial Support workers.

## ***What does a Psychosocial Support worker do?***

Psychosocial Support workers can be found working in Community Mental Health and Wellbeing Sector services across a broad range of non-government organisations (NGOs) that primarily deliver psychosocial and wellbeing supports in the community. By working with people to build their natural resources and personal agency, they are well-positioned to extend primary care through social prescribing in the primary care space. For example, they:

- Help people to identify their wellbeing goals and develop a plan – essentially a co-designed social prescription - to engage with appropriate supports that can help them to achieve this.
- Use recovery-oriented, trauma-informed skills and knowledge when working with people to reestablish their lives beyond illness.
- 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.
- Reduce social determinants for mental health by taking a whole of life approach and supporting people to navigate and respond to their broader needs including housing, employment, legal issues, family support and alcohol and drug challenges.

- May draw upon their personal life-changing journey of mental health challenges, service use and recovery to coach others on their recovery journey if working in lived experience peer worker roles.
- Uphold a human rights approach which values least restrictive practice and operate from a social justice framework, that can empower individuals and communities to change structural inequalities.

While highly skilled, the current Community Mental Health and Wellbeing Sector workforce does not necessarily come from the clinical groups commonly seen in primary care. Instead, the workforce is diverse, often brings a lived experience lens and has the potential to be scaled up quickly and easily through TAFE qualifications, typically the Certificate IV in Mental Health or Certificate IV in Mental Health Peer Work. A recently completed survey of the Community Mental Health and Wellbeing workforce in Queensland [3] found that qualifications commonly sought by employers in the sector are:

- Bachelor degree – 52 per cent (Social Work, Psychology, Counselling, OT)
- Certificate IV Mental Health – 33 per cent
- Certificate IV Mental Health Peer Work – 30 per cent

Overall, we believe that there is a significant opportunity to mobilise this workforce and redesign the current mental health ecosystem to deliver more cost-effective, person-centred and responsive mental health and wellbeing services that focus on early intervention in life as well as illness, and address the needs of the large cohort of people experiencing moderate-severe mental illness known as the “missing middle” [7] who would otherwise access support via GPs.

We suggest that the Community Mental Health and Wellbeing Sector is well placed to achieve these aims and ease the load on primary care services in two ways:

- through better recognition of and access to Community Mental Health and Wellbeing Sector services, that are upscaled and funded through Primary Health Networks to provide greater access separate from primary care; and
- by encouraging referral from primary care to Community Mental Health and Wellbeing Sector services for psychosocial support to develop social prescriptions (i.e. social prescribing - see below).

## What is social prescribing?

Social prescribing is an innovative practice that seeks to improve overall wellbeing in non-medical ways in conjunction with healthcare workers [22]. QAMH is advocating for a general model of social prescription in which individuals seeking support for their mental health are able to work with a

Psychosocial Support worker (also known as a community link worker or community navigator within the literature) to co-create their own social prescription, with or without referral from a GP. Utilising a community-based link worker would ease pressure on GPs and also create a suitable point for GPs to refer into. QAMH believes 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. This work should be planned looking to utilise the current network of community mental health and wellbeing services in each location and through existing community entry points such as Head to Health Centres, community mental health hubs and other community locations as the natural infrastructure is easily scaled up for this work.

Social prescribing and the associated non-medical supports such as arts and social programs that people are referred into are gathering significant interest as evidence-based, affordable, and complimentary to more conventional treatments such as prescription medications and referrals to psychologists [see for example 12, 7, 13, 16, 15]. It is also a practice that we know GPs are interested in, with The Royal Australian College of General Practitioners noting that many GPs are already incorporating a form of social prescribing into their day-to-day practice and now calling for it to be officially included in the Federal Government's 10-Year Primary Health Care Plan.

The benefits of this approach are summarised below. Evidence from the literature is annotated in the text boxes and referenced in the subsequent section.

## Benefits of this approach

### Value to the Consumer

- Support to address underlying social determinants that can help people to break the cycle of contributing circumstances that lead to poor mental health [see for example 14].
- Increased satisfaction that services can respond to actual needs rather than treating symptoms alone, as support seeks to address the root causes of mental distress.
- Less traumatic entry into the system, by providing “safe” initial access points with specialised support away from GP clinics, emergency departments or other settings that may be traumatising to the person experiencing distress [see for example 9, 10, 11]. Psychosocial Support is often informed by a lived experienced lens, which may be valued by consumers.
- Reduced rates of re-hospitalisation, resulting in fewer negative socioeconomic impacts [see for example 14].
- Improved mental wellbeing and socioeconomic participation, long term, including access to earlier intervention that reduces the likelihood of early mental distress escalating to require acute intervention.

### Value to other primary care professionals

- Reduced burden on GPs who may feel ill-equipped to manage the specialised support needs of people experiencing moderate-severe mental illness and who currently require GP support to access medication or other services.
- Expands the range of high quality, evidence-based treatment options that GPs can refer people to.
- Reduces wait-list times for Allied Health services, enabling higher customer satisfaction and greater ability to prioritise those with higher needs.

### Value for the Mental Health Ecosystem (including Funders and Government/s)

- Faster pipeline of workers due to shorter qualification requirements and a more easily scalable specialist workforce, that reduces workforce shortages
- Improved community access to supports that reduce the number of people using the hospital system as a first entry point and frees up emergency departments and acute bed-based services, saving these high-cost resources for more acute and severe presentations.
- Interventions that break the cycle of mental ill-health by addressing social determinants, and therefore reduce the need for ongoing expensive crisis intervention responses.
- Reduced duplication and competition between services.

### Value for the Community

- Reduced burden on carers and other social support systems, by increasing support for those with moderate-severe mental illness who may not currently be able to access support (“missing middle” [7]).
- More accessible and locally designed initiatives that meet community expectations.
- Reduced community stigma regarding diverse mental health experiences through the normalisation and encouragement of using community-based mental health and wellbeing services.
- Increased socioeconomic participation and productivity.
- Increased community mental wellbeing and “mental wealth” (i.e. the value created by social contributions (or social productivity) and social capital infrastructure that strengthens communities and enables human flourishing [29]).

### ***Evidence from the Literature – Current Unmet Needs***

The Productivity Commission [7] identified a group of as many as one million Australians who are considered too unwell to be treated in the primary care system but are not deemed sick enough to be treated by acute services. Termed “the Missing Middle”, this cohort fall between the cracks of federal and state funding and cannot necessarily afford to access private support.

The Australian Institute of Health and Welfare [30] identified that most primary mental health care is provided by GPs and the most common intervention is medication. In 2021-22 there were 44.4 million mental health related prescriptions provided to 4.7 million people [5]. The majority of prescriptions were made by GPs (85%) and Antidepressants (74%) were the most common mental health-related prescriptions dispensed [5]. In 2021-22, almost 2.8 million people (11% of Australians) accessed 13.6 million Medicare-subsidised mental health specific services [6].

Dawson et al. [9] and Figley and Kleber [10] suggest that access points such as GP clinics and emergency departments may be traumatising for people who have experienced trauma as they may trigger memories about traumatic experiences through invasive procedures and coercive practices (for example, the removal of choice regarding treatment or judgmental attitudes following a disclosure of abuse; lack of available and acceptable services) when accessing mental health support.

Harris and Falloot [11] found that re-activation of traumatic experiences within health services can affect both service users and staff, with the latter experiencing vicarious trauma.

### ***Evidence from the Literature – Social Prescribing***

Dingle [15] recently completed an 18-month evaluation of social prescribing programs in Queensland in which people were linked via community-based link worker to community services and social activities to reduce loneliness and social isolation. The evaluation found that in only 8-weeks of social prescription, participants showed significant improvement in

### ***Evidence from the Literature – Social Determinants***

World Health Organisation (WHO) [12] called for action “as many of the causes and triggers of mental disorder lie in social, economic, and political spheres – in the conditions of daily life.”

Productivity Commission [7] highlighted the importance of community mental health and wellbeing services as a critical part of the mental health system, saying there has been a “disproportionate focus on clinical services”.

Productivity Commission [7] stated that “housing, employment services and services that help a person engage with and integrate back into the community can be as, or more, important than healthcare in supporting a person’s recovery”.

House of Representatives Select Committee into Mental Health and Suicide Prevention [18] noted that “clinical interventions, in the absence of broader measures to address social determinants of health, cannot resolve growing mental health concerns in Australia”.

Social Policy Research Centre [14] evaluated NSW Community Living Supports and Housing and Accommodation Support Initiative (CLS-HASI) and found that:

- Overall the programs improved wellbeing, helped people better manage their mental health, enhanced aspects of consumers’ physical health and increased opportunities for social inclusion.
- Consumer contact with community mental health services decreased by 10% in the first year in CLS-HASI and was 63.7% less if they remained in the programs for more than one year.
- Hospital admissions due to mental health decreased by 74% following program entry, and the average length of stay decreased by 74.8% over two years. This improvement was sustained after consumers exited the programs.
- Consumers with a new charge in the criminal justice system and with community corrections orders dropped to almost zero in the year after program entry.
- The programs are generating more in cost offsets than the cost of the programs, with a net cost saving per person of about \$86,000 over 5 years. Over 90% of the cost offsets were for reduced inpatient hospital admissions and lower lengths of stay.

### ***Evidence from the Literature – Social Determinants (cont.)***

Fancourt and Finn [16] conducted an extensive 2019 review of more than 3,700+ studies investigating the role of the arts in improving health and well-being Fancourt and found:

- a strong positive impact of the arts on both mental and physical health. Conducted on behalf of the World Health Organisation (WHO), this is the most comprehensive survey of its kind to date.
- some studies showed that arts interventions may be as effective or even more effective than widely accepted approaches such as medication, non-arts social interventions or other health interventions such as exercise.
- that not only are arts interventions effective, but they also hold economic benefits that may be equal to or greater than the cost-effectiveness of possible health interventions. This is because arts interventions were often found to be multi-faceted, offering several health-promoting factors and reducing the need for other interventions, for example by supporting physical activity with components that also support mental health. They were also found to be
- arts interventions are an effective route to engaging minority or hard-to-reach groups, who can have higher risks of poor health and for whom health-care costs may otherwise be higher, due to complexity.

National Mental Health Commission Inquiry into Social Isolation and Loneliness [13] cited two loneliness intervention programs for older people to address social isolation, and reported that an assessment of their cost effectiveness indicated a positive ROI ratio and associated cost savings based on an analysis of cases of mental illness prevented.

Community Support and Services Committee [13] cited a 2017 UK study into the benefits that the arts can bring to people's health and wellbeing and Associate Professor Dingle who stated: "I feel like we have underestimated the importance and the impact of these social care options. It is not to replace anything; it is really that we need to think of them and take them seriously as a part of health."

## Risks and challenges

We have identified the following key risks and challenges which are explored further below:

- Lack of awareness of Community Mental Health and Wellbeing Sector Services
- Ensuring enough services and activities are available to meet demand
- Changing the way we work

### ***Lack of awareness of Community Mental Health and Wellbeing Sector Services***

Traditionally, Community Mental Health and Wellbeing services are regarded by people receiving care as a welcome alternative to clinical intervention, because they offer practical support, coaching and life skills. Many services have also developed models based on consultation with participants. Yet beyond those who have engaged with services, the general public knows very little about the Community Mental Health and Wellbeing Sector. Most mistakenly believe community mental health care is actually private therapy accessed through a GP. The public - and potentially GPs themselves - are largely unaware about the support that could be provided by the Sector, and it is therefore underutilised. Although some providers run multimillion dollar national organisations, the Sector is made up of many small and large organisations that have often grown around a unique offering in a particular region. This evolution has resulted in funding gaps leading to inconsistent expectations of what the Sector and its workforce can deliver. As such, the specialisation and unique contribution of the Community Mental Health and Wellbeing Sector to individuals, communities and the wider mental health ecosystem is not well understood, undoubtedly underutilised and not generally advocated for within the public discourse.

### ***Ensuring appropriate services and activities are available to meet demand***

Psychosocial Supports beyond “navigation and linking” services alone are required. Even the best online navigation tool or community link worker won't help a person if there's nothing to navigate to: sufficient services and activities need to be available in the community for Psychosocial Support workers to refer into, and these services need to be appropriate and accessible for those experiencing mental distress.

QAMH believe that this must be more than simply listing a whole lot of community groups that are available - these activities need to be well-supported and include Psychosocial Support workers who are trained in how to respond to someone in mental distress. The risk of not paying adequate attention to the entire “ecosystem of support” is highlighted by Dr Giurca in the Inquiry into Social Isolation and Loneliness in Queensland report [21] where he states:

*“... it cannot be understated the importance of ensuring that the local ecosystem is built before social prescribing is being delivered as an initiative. We have seen different areas across the UK where link workers are struggling because there are*

*not enough opportunities within the community. In the UK, funds such as the Thriving Communities Fund, which you can look at, tries to do just that. It tries to find gaps of opportunities within the local community, especially those most impacted by COVID or those most at risk of social determinants, and provide them with extra seed funding to develop the local community infrastructure. ... It is crucial to realise that social prescribing will not exist unless there are those community support groups and unless they are being supported, otherwise it feels like we are shifting some of the patients from [Accident and Emergency] into the community.”*

Ultimately, we believe considering the service ecosystem as a whole is important and that this is best done in a localised, co-designed manner that builds on local assets.

### ***Changing the way we work***

Integrating Community Mental Health and Wellbeing Services successfully with primary care will require a cultural shift within the health care system. Unfortunately - despite the recommendations of multiple inquiries to date - the system is stuck in a cycle, holding on to the core belief that medical intervention is the main solution to the problem. The Productivity Commission (2020) highlighted the following key barrier to the reform of the mental health system, leading to poor outcomes for people:

*“Supports that are below best practice — in part due to a lack of measurement and evaluation of what works, and in part due to a culture of superiority that places clinicians and clinical interventions above other service providers, consumers and their families and carers [24].”*

QAMH believes that the challenge in changing the way the system works lies partly in the need for a cultural shift within government and the clinical professions to recognise that not all distress requires a medical response. However, we also believe that the system requires a new model of care that builds in structural levers to assist the change – for example incentives and tools such as funding the gap in psychosocial support and developing a national social prescribing framework - alongside educational campaigns regarding how primary care can work in a more integrated way with Community Mental Health and wellbeing services. We are hopeful that once these initial barriers are overcome, the benefits of working in such an integrated way will encourage a groundswell of change, driven by practitioners themselves.

## Real life examples of full or expanded scope of practice in multidisciplinary teams in primary care

There are a number of examples of successful social prescribing initiatives already in existence. In its recent report *Connected Lives: Creative solutions to the mental health crisis* [22], the Australia Council for the Arts recommended development of a national social prescribing scheme that draws on “the very effective and locally appropriate models that already exist in Australia rather than simply borrowing those from overseas contexts.” In Queensland, a number of programs have already been evaluated and found to deliver promising results [23].

We are aware of the following social prescribing initiatives in Queensland:

- Ways to Wellness is a collaboration between the Mt Gravatt Community Centre, Mt Gravatt Men’s Shed, Queensland Community Alliance and the University of Queensland. It aims to tackle social isolation and loneliness with a whole-of-community approach. People in the community who are experiencing social isolation can self-refer to the service or be referred by their GP or allied health worker. Once referred, a Community Link Worker connects members of the community experiencing social isolation to meaningful group programs and activities.
- Wesley Mission Queensland has partnered with Australia Council for the Arts to pilot an ‘Arts on Prescription’ program, which encourages participation in arts and cultural pursuits to address the social determinants and social isolation that contribute to mental illness. Arts on Prescription acknowledges that resources already exist in the community to improve our wellbeing beyond the traditional health system. The program aims to tap into these resources and give health professionals, including GPs, new ways of connecting people with arts and cultural endeavours. This project is still in its early delivery phase however an evaluation process is soon to be commenced.
- Brisbane South PHN - Footprints Care Coordination Service program has been running since 2018. It supports people with who are at high risk of hospitalisation, with the aim being to catch them before that eventuates. They have 2.5 full time equivalent care coordinators who coordinate care across psychosocial support, housing, jobs, community, disability and Centrelink. Initially it was GP referral only however it has now grown to include referrals from pharmacists, nurse navigators, aged care navigators, the Mater Refugee Complex Care Clinic and any community health hubs/centres. They have several GP surgeries involved in the coordination service and their KPIs for 2023 are to have 175 referrals. Once referred into the service consumers are given a care plan to start the process.

As noted by the Australia Council for the Arts in 2022 [22], we already have the template for successful social prescribing right here in Australia: what we need is greater coordination and upscaling of existing initiatives, plus political will to make it happen.

## Facilitating best practice

### What barriers can government, employers and regulators address to enable health practitioners to work to their full scope of practice?

#### *Gated Entry Points and Eligibility Criteria*

Gated entry points also serve as a barrier within the current system and contribute to the pressure on the primary care workforce. Currently, people enter the system through a variety of channels, with the most common entry points being attendance at a GP clinic, presentation to an emergency department, or calling 1300 MH CALL. More recently, the Head to Health service delivery model has created a centralised pathway for consumers with patients triaged by registered Mental Health nurses who assess their needs and select the right provider for their care.

Referral to Community Mental Health and Wellbeing Sector services directly from GPs is not widespread. This may be because of a distinct lack of knowledge of the existence of these services by clinicians and historical practices established within the Better Access Initiative. In most cases – except for the Head to Health referral pathway - the result is that people remain within very narrow (clinical) pathways, usually involving prescription of medication, referral to a psychologist under the Better Access Initiative, or transfer to one of the state-funded Hospital and Health Services (HHS). While some people get referred to a Community Mental Health and Wellbeing service through one of these channels, direct entry into these community services is not part of the current funding arrangements for the majority.

There is a strong argument for each community in Australia to have an accessible front door where people experiencing moderate to severe mental health challenges can access the system, receive initial information about the suite of clinical and non-clinical services available and associated out-of-pocket costs, and help connecting them to these services. The rollout of Head to Health Services hold promise to serve this function although currently not accessible throughout regional and remote Australia. We hope the introduction of Head to Health will prevent, in many instances, the unnecessary medicalisation of mental distress which does not always need a clinical response and take the pressure off a hospital system struggling under the weight of demand. However we are wary that due to the increasing demand they are at risk of becoming another conduit into the clinical system rather than a resource that builds people’s skills and capacity to manage their illness and engage with community.

Another flaw of the current system is that funding models are often attached to excessive eligibility criteria, resulting in cases where people may be ‘locked out’ of service delivery due to restrictive funding mechanisms. For example, Queensland Health funded services are available only to those

referred by the Hospital and Health Service (HHS), Primary Health Network (PHN) funded services requiring GP referrals, or psychologists needing mental health care plans to be completed by a GP. When one understands how difficult it can be to ask for help in the first place, it becomes apparent that a system designed to put up administrative hurdles for people to jump is not one conducive to recovery.

### ***Workforce Development and Training***

While the Community Mental Health and Wellbeing Sector workforce is undoubtedly comparatively easily scaleable, it faces workforce challenges of its own. In Queensland, these are detailed in our Workforce Issues Paper [26] and are currently being addressed via development of a Workforce Strategy specific to our sector. Other states and territories (e.g. NSW and ACT) are beginning similar work. There will however, need to be a national strategy to build and grow this much needed workforce.

Widespread education of the clinical workforce regarding the functions and value of the Community Mental Health and Wellbeing Sector, potential referral pathways and the association between social isolation and other social determinants with mental health challenges is also required. Training should highlight that the Community Mental Health and Wellbeing Sector, with its focus on accessible community-based programs which operate within a wellbeing and early intervention framework, is perfectly positioned to tackle this issue.

### ***Competitive Funding Environment***

The current fiscal landscape, which is based on grant funding through State Governments and Primary health Networks (PHNs) or individual fee-for-service funding through the NDIS and Medicare, encourages services to operate as silos [28]. This is not in the best interests of people experiencing mental distress and is an abrupt change from the pre-NDIS environment where services operated more collaboratively in networks of community-based care. Prior to the NDIS, through programs such as Partners in Recovery (PIR) and Personal Helpers and Mentors (PHaMS), service providers would refer people to each other's programs, draw on each other's strengths and knowledge, and work together to provide the best outcomes for people in distress.

## **What enablers can government, employers and regulators address to enable health practitioners to work to their full scope of practice?**

### ***Removal of Gated Entry Points and Eligibility Criteria***

While medical responses are necessary, they are not the only strategy to manage distress and mental wellbeing. There is a role for a range of services to make up the mental health ecosystem and it is

essential that community mental health and wellbeing services become more natural places to access help early in a person's recovery journey. Redesigning entry points so that there is less reliance on eligibility criteria, that enable self-referral as a valid entry to the system and that recognise that clinical pathways are not the only journey to recovery is required. When designing such a system, careful attention must be paid to ensuring it remains easy to navigate and focused on local services rather than providing standardised, one-size-fits-all solutions.

QAMH acknowledges the intent of Head to Health centres, which is to provide a direct entry point and service early in distress by providing short-term supports. We also appreciate the importance that has been placed on lived experience workers in the Head to Health centres, with the philosophy that 'Wellbeing Coaches' support people from when they arrive to when they are ready to leave, and clinicians are not the default providers of care. We keenly await the evaluation of these pilot centres, in particular whether they are able to reach the missing middle and cope with demand, how they balance clinical versus nonclinical care, whether they can provide targeted wellbeing responses, and whether there are adequate funded services available for onward referrals.

QAMH recommends the following specific strategies to help address these issues:

- Review the effectiveness of Head to Health pilot centres with particular attention to who is using the services and the wellbeing outcomes (both short and long term) of people's engagement with the service.
- Explore options to raise awareness of Psychosocial Support as mental health referral pathway and consider incentives that encourage GPs and other professionals to refer directly to Community Mental Health and Wellbeing services who can assist consumers to develop a social prescription for non-medical supports.

### ***Including the Community Mental Health and Wellbeing Sector Workforce in Workforce Planning***

QAMH believe greater awareness and integration of Community Mental Health and Wellbeing services into primary care present an opportunity to expand the scope of health services and maximise the value of national workforce resources through relatively quickly scalable, high-quality and evidence-based services. Preparing the workforce for such a transition will be important.

QAMH recommends the following specific strategies to help address these issues:

- That the Australian Government includes the Community Mental Health and Wellbeing Sector workforce in the National Mental Health Workforce Strategy (along with GPs, nurses, psychiatrists, psychologists and social workers), and provides opportunities for the Sector to be represented at federal and state workforce discussions and that establish more direct lines of communication between the Sector and decision makers.

- A comprehensive training and awareness campaign is developed for clinical professions and Allied Health professionals regarding the functions and value of the Community Mental Health and Wellbeing Sector, potential referral pathways and the association between social isolation and social determinants of health with mental wellbeing. Training should highlight that the Community Mental Health and Wellbeing Sector, with its focus on accessible community-based programs which operate within a wellbeing and early intervention framework, is perfectly positioned to tackle this issue.

### ***A Whole-of-Government Approach to Mental Health Funding***

QAMH has long been advocating for a whole-of-government approach to mental health funding. We recommend a future system where funding models incentivise cooperation between services to provide collaborative care delivered by multidisciplinary teams. Likewise, prioritising approaches which provide practical early intervention responses early in distress through social prescribing and/or that facilitate greater access to, funding and recognition of Community Mental Health and Wellbeing Sector services would allow more expensive medical interventions to be used where they are most needed and most effective.

QAMH recommends the following specific strategies to help address these issues:

- Development of a national social prescribing framework. General features of a model for social prescription involve a community-based link worker/psychosocial support worker/community navigator to ease pressure on GPs and create a suitable point for GPs to refer into, whom individuals seeking support for their mental health can work with to co-create their social prescription. QAMH believe that encouraging communities to consider their own naturally occurring community resources and co-design a model suited to their own local context for GPs to refer into will be a key design feature of a successful social prescribing scheme.
- Better funding for, and expansion of, Primary Health Networks to identify local community health service needs specifically for preventative and early intervention services and Community Mental Health and Wellbeing Sector services in rural and remote areas.
- Work with State Governments to develop new agreements that ensure that the gap in funding for Psychosocial Support is properly addressed.

Thank you for the opportunity to contribute to this consultation process. We look forward to continuing to work with the Australian Government to better the lives of people living with mental distress. Please do not hesitate to contact QAMH should you require any further information.

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