leading community mental wellbeing

Queensland Alliance for Mental Health

2022 Federal Budget

Pre-Budget Submission

August 2022

Who is QAMH?

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

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QAMH Priorities for 2022 Federal Budget

1. **Put 'Mental Wellbeing' at the centre of the wellbeing budget, apply a whole-of-government approach where every minister is held accountable to wellbeing measures as part of their portfolio, and consider a wellbeing measure based on the concept of 'mental wealth'**

2. **Ensure the National Mental Health Workforce Strategy explicitly and comprehensively plans for the development and growth of a contemporary community mental health workforce**

3. **Increase investment in the non-governmental community mental health and wellbeing sector to bridge the service gaps, in particular:**

    a. **the Primary Health Network's low intensity mental health services focused on wellbeing and targeted at early intervention**

    b. **the Primary Health Network commissioned services which address the mental health needs of the Missing Middle, including those with moderate to severe symptoms who remain ineligible for the National Disability Insurance Scheme (NDIS)**

4. **Ensure Primary Health Network contracts are consistently five years in length and include indexation which accurately reflects the increased costs of business**

5. **Reform the NDIS by reviewing the pricing arrangements, thin markets in rural and remote areas, looming workforce shortages, and the appropriateness of the NDIS model for psychosocial disability**

6. **Establish a broader network of community alternatives to emergency departments**

Background

The reform of Australia's mental health system is at a critical juncture. In response to the Productivity Commission's scathing report into mental health, which showed that the country's mental health system was crumbling under the weight of demand and gave clear recommendations for transformational change, the previous government invested almost $3 billion in mental health and suicide prevention. The details of this were formalised in the National Mental Health and Suicide Prevention Agreement. While welcomed as an initial down payment, these developments fall well short of the investment needed to implement the systemic changes required. In fact, rather than being the promised platform for transformational mental health reform, the National Agreement and two recent federal budgets have fundamentally failed to address the advice provided by the Productivity Commission, including properly investing in community mental health and wellbeing services, embedding lived experience, and addressing looming workforce issues.

A seismic shift is needed to fundamentally improve the lives of Australians living with mental distress. This Federal Budget needs to align with evidence provided to the Productivity Commission, the House of Representatives Select Committee on Mental Health and Suicide Prevention, the Royal Commission into Victoria's Mental Health System and, most recently, the Queensland Parliament's Inquiry into the Opportunities to Improve Mental Health Outcomes for Queenslanders. All of these inquiries have overwhelmingly recommended a broad reform agenda. Injecting more money into the same traditional models of care will not bring the systemic changes required. While increased investment is needed, we need to redesign how that investment is planned and distributed. QAMH is calling for structural reforms which support co-designed models of care that deliver the right services at the right time, build economic and social participation, and invest in the mental wellbeing of all Australians.

Bringing about the transformational change required will be costly. But the significant investment required needs to be weighed against the cost of inaction. According to the Productivity Commission, in 2018-2019 the annual cost to the economy of mental ill health and suicide in Australia was as much as $70 billion. This is made up of $16 billion directly spent on mental health care, $39 billion on lower economic participation and lost productivity, and $15 billion in replacing the support provided by family and/or friends. In addition, the cost of disability and premature death due to mental illness, suicide and self-inflicted injury was equivalent to a further $151 billion per year. That is a powerful economic rationale for committing to ambitious and meaningful reforms that will transform the lives of Australians living with mental distress.

Put Mental Wellbeing at the Centre of the Wellbeing Budget and Ensure a Whole-of-Government Approach

QAMH welcomes the Treasurer's announcement that the government's first budget will include a discussion of options to measure the nation's collective wellbeing, alongside traditional economic markers. This aligns with our strong belief that the nation's social and economic pursuits should be centred around activities which enhance Australians' wellbeing and allow them to live a good life. Economic markers such as GDP do not truly capture the nation's prosperity and have little relevance to Australians' day-to-day lives. A wellbeing approach also necessitates whole-of-government and whole-of-society perspective – something QAMH has long been calling for. As the government embarks on this process to fundamentally rethink what has real value, and how we define, measure, model and forecast national prosperity, we ask them to:

- Recommend mental health and wellbeing one of the central domains measured – and not rolled into an overall health measure including physical health
- Embed the wellbeing approach across the entire public sector so that all government department's priority setting, strategic planning and budgetary decisions are subject to accountability though a wellbeing lens
- Consider using Mental Wealth as an overall measure of national prosperity
- Consult with the Community Mental Health and Wellbeing Sector in any process that involves selecting wellbeing measures

Comprehensive Planning and Development of the Community Mental Health Workforce in the National Mental Health Workforce Strategy

QAMH is calling for the community mental health workforce employed by non-government organisations to be properly included in the National Mental Health Workforce Strategy (the Strategy). We were disappointed to see the draft Strategy largely ignore this important component of the workforce, with only tokenistic references to community mental health workers. Instead, the Strategy needs to focus on more than just the 'big five' health professions – doctors, nurses, psychologists, occupational therapists and social workers – and look to the highly skilled community workforce that is already providing a diversity of services and achieving positive outcomes in the community.

In particular, the Strategy needs to:

- Evaluate and plan for the quality, supply, distribution and structure of the community mental health workforce and put forward recommendations for future workforce development.
- Invest in the development of contemporary education and training qualifications for the community mental health workforce, and evaluate whether current qualifications such as the Mental Health Certificate IV are contemporary or whether a new skills base is needed.
- Provide financial support to organisations to encourage student placements for TAFE and tertiary training qualifications, to ensure students are appropriately equipped to enter the community mental health workforce.
- Elevate and strengthen the Lived Experience workforce across all parts of the service system, with commitment to appropriate remuneration structures and career progression.

Investing in the NGO Community Mental Health and Wellbeing Sector to bridge service gaps

Recent reports, inquiries and royal commissions have made it clear that Australia's mental health system is failing to address the needs of millions of people living with mental distress. At many points along a person's mental health trajectory, there are gaps in the ability to access care. The two key gaps identified by the Productivity Commission in its landmark 2020 report are:

- The low intensity gap, and
- The missing middle gap.

QAMH is calling on the Commonwealth government to increase funding to the PHN-commissioned psychosocial services which are well positioned to address these two gaps.

The Low Intensity Gap

The Productivity Commission report states that up to 500 000 Australians who are not currently accessing any mental healthcare would benefit from greater access to low-intensity services. In addition, up to two million people who currently take mental health medication or access individual psychological therapy (or both) could similarly benefit from greater access to low-intensity services. These services have demonstrated equitable efficacy to medication/psychology but cost less, take less time, are easier to access (often without a referral) and have fewer adverse side effects.

Low intensity services are currently commissioned by the PHNs via their Flexible Funding pool and include programs such as New Access which is a coaching program using cognitive behavioural therapies and gives people practical help with life stressors. Low intensity services also include peer support, services with a focus on building resilience and wellbeing, and programs that connect people to naturally occurring community supports such as sporting clubs and creative arts programs. These services, which focus on wellbeing and flourishing, provide intervention early in an episode of mental distress. They are evidence-based, relatively low cost and reduce the burden on acute services.

Currently, of the $148.7 million allocated to Queensland's seven PHNs for mental health funding in 2021-22, only $4.5 million was spent on low intensity services.[1] This is despite the overwhelming evidence that increased investment in prevention and early intervention is a cost-effective way to reduce overall burden on the mental health system. In order to stem the tide, it is critical that the Commonwealth reviews the distribution of mental health funding, which is currently weighted towards more acute presentations, to ensure that these early intervention services are properly funded.

Finally, the current guidelines for PHN commissioned activities stipulate that "community wellbeing activities aimed at improving connectedness….are not considered to be low intensity mental health services and are generally seen as being out of scope of the Flexible Funding pool".[2] We disagree with this exclusion criteria, especially considering the overwhelming evidence which links loneliness and social isolation with mental illness. QAMH is calling on the Commonwealth to broaden the scope of this commissioning criteria to include services that focus on wellbeing outcomes including connecting people to naturally occurring community resources.

The Missing Middle Gap

The Productivity Commission identified "several hundred thousand" Australians who fall into the "missing middle", a term which refers to the large and growing number of people whose situation is considered too complex to be treated in the primary care system but are not deemed unwell enough to be treated by acute services.

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[1] Primary Health Networks of Queensland. (2022). *Submission to the Mental Health Select Committee's Inquiry into the Opportunities to Improve Mental Health Outcomes for Queenslanders* (No. 107). 00000107.pdf (parliament.qld.gov.au)

[2] Australia. Department of Health. (2019). *PHN Primary Mental Health Care Flexible Funding Pool Programme Guidance: Low Intensity Mental Health Services for Early Intervention*. PHN primary mental health care guidance – low intensity mental health services for early intervention

One of the most significant contributing factors has been the rollout of the NDIS, as only a fraction of the people living with moderate to severe mental illness will ever meet the criteria to receive an individual funded plan. According to the Productivity Commission, two million Australians are living with moderate to severe mental illness at any given time. But just 64,000 will meet the strict eligibility criteria to access the scheme. When services underwent the major transition to NDIS funding, they were forced to focus on service provision for those with funded plans. This has left a gaping hole in the system, with many people ineligible for an NDIS package unable to access any programs at all.

QAMH urges the Commonwealth to properly consider alternative funding channels to provide services for these people, and specifically recommends the Community Mental Health and Wellbeing Sector to fill this gap. We need a national solution to address the gap in psychosocial supports for people living with moderate to severe mental illness. The current National Psychosocial Support Measure, which was targeted in the National Agreement for further evaluation, is not adequately funded to meet the needs of Australians with moderate to severe mental ill health, who are unable to access the NDIS. We urge the Commonwealth to expand its investment in PHN-commissioned programs which address the needs of this vulnerable population.

Revising Terms of Contracts

QAMH is calling for the Commonwealth to review funding of PHN contracts to:

- Extend the length of the funding cycle to a minimum of five years and ensure renewal processes occur with adequate lead time. Both the Productivity Commission's report and the House of Representatives Select Committee's final report recommended that funding transition to five yearly cycles (up from 1-3 yearly). The relationships between contract length and sustainable service delivery, service quality and workforce attraction, are interconnected. Without longer funding cycles, community mental health organisations will continue to be plagued by high staff turnover, lack of permanent employees, and inability to implement any lasting service delivery changes.
- Increase indexation. QAMH understands PHN contracts are not indexed at rates reflective of the increased cost of providing services in recent years.
    - From July 1 2022, employers must implement the Fair Work Commission's 4.6% increase to modern awards, including the Social, Community, Home Care and Disability Award under which most of the community mental health sector is employed.

- In July 2021, the Superannuation Guarantee rate increased from 9.5% to 10%, with a further 0.5% increase imposed from July 2022.
- Rent increases are generally outstripping inflation, with residential increases averaging 2% and commercial (including retail and office space) around 3%.
- Cost of equipment, stock purchases, electricity and fuel has increased significantly over the past 12 months.

Community mental health and wellbeing organisations have clearly been subjected to significant cost increases in the 2021-22 year. This has led to a scaling down of services in some instances in order to cover the costs of doing business. Indexation of contracts must better reflect this exponential increase in delivering community mental health and wellbeing services.

Reforming the NDIS

Since its rollout in 2016, the NDIS has provided a life changing opportunity for many Australians living with psychosocial disability. In many instances, it has allowed them to access supports and services they require to exercise choice and control and effectively participate in society. However, the NDIS has not been without problems. In particular, QAMH is calling for the Commonwealth Government to:

- Review the pricing arrangements to ensure line items accurately reflect operation costs. The recent 9% increase to price limits for NDIS supports delivered by disability support workers was welcomed by the sector. However, the flawed assumptions underpinning this model do not accurately reflect the cost of doing business, meaning that providers of psychosocial disability services fail to recuperate costs. The cost of providing satisfactorily remunerated employment, suitable working conditions, and adequate supervision is not covered under the current model. Another issue is the provision of staff training required to comply with standards and to provide quality supports to people accessing services. Staff recruited from the disability sector and those with generic disability qualifications (e.g., Certificate III Individual Support) require training to understand the very specific needs of people receiving psychosocial supports. It is also not uncommon to recruit staff to work in the NDIS with no formal qualifications, particularly in rural and remote regions where there is a lack of qualified applicants. The significant cost of this training is currently absorbed by service providers, but this is not a sustainable model going forward.
- Review the pricing arrangements specifically in remote and very remote areas. The current pricing arrangements are insufficient to entice providers into these areas. Thin markets have

developed because the pricing arrangements do not reflect real world operating costs of delivering services in remote and very remote areas, including things such as travel, training, and other incentives required to attract appropriately trained staff. This limited workforce means that people with psychosocial disability living in these areas miss out entirely on critical supports and a lack of choice and control, a fundamental principle of the NDIS. Consideration should be given to setting price limits which accurately reflect the challenges associated with delivering services in rural and remote areas.

- Develop a strategy to combat the unfolding catastrophe in the NDIS workforce. The NDIS National Workforce Plan 2021-2025 reports that 83,000 new workers are needed by 2024 to meet growing demand, equivalent to a 31 per cent increase in the size of the workforce. We urgently need a proper workforce strategy which includes clear training pathways, enough opportunities for student placements, opportunities for proper career progression, adequate renumeration, and a strategy to address casualisation of the workforce.
- Evaluate the appropriateness of the NDIS model when applied to psychosocial disability to determine whether this is the right way to fund psychosocial supports in the long term. The disability model that underpins the NDIS is diametrically opposed to a wellness and recovery framework. This focus on disability and permanent functional impairment is stigmatising and does not align with how the sector sees mental distress and the recovery journey. The NDIS was initially established to address the needs of people living with physical and intellectual disability. Psychosocial disability, with its fluctuating/episodic nature and ongoing attempts to achieve personal recovery, was retrofitted into the scheme and providers constantly struggle to provide services in this poorly funded, rigid, dependency-based model.

Alternatives to Emergency Departments

Emergency departments remain one of the most common points of entry to the mental health system. Unfortunately, they are also one of the most distressing places for people experiencing mental health challenges and are not conducive to trauma-informed care. In recent years, there have been a range of initiatives to offer alternatives to emergency departments, many of which are in the early stages of implementation and as such have not yet undergone formal evaluation. In Queensland, these include four safe space hubs in the Brisbane North Primary Health Network and, to a limited extent, the federally funded Head to Health centre in Townsville, with more to be rolled out as part of the National Mental Health and Suicide Prevention Agreement. However, these initiatives, while welcome, do not provide real alternatives to emergency departments as they lack adequate funding and the ability to open for extended hours. They are also too few in number to truly meet the demand.

There is an urgent need to establish a network of alternatives to emergency departments that are led by community organisations, staffed primarily by people with lived experience, open 24/7 and accessible when the person in distress needs support. These warm community entry points would be more approachable and less daunting for people in crisis, providing welcoming spaces for private conversations conducted with dignity, and an environment conducive to de-escalating people's distress. There is a large and growing body of evidence to support the positive outcomes of these types of approaches. These not only include benefits for the person accessing the service, but fewer hospitalisations and reduced use of emergency departments and acute services.

Thank you for the opportunity to contribute to the 2022 Budget 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.