FEEDBACK ON THE DRAFT REPORT FROM THE PRODUCTIVITY COMMISSION INQUIRY INTO MENTAL HEALTH

"Strong, inclusive and resilient mental health communities."

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To the Productivity Commission,

SUBMISSION: Feedback on the Draft Report for the Inquiry into Mental Health

The Queensland Alliance for Mental Health (QAMH) is the peak body for the community mental health sector in Queensland. We represent more than 100 organisations and stakeholders and work together to build capacity, and to advocate for sector development to best meet the needs of those experiencing mental health issues in our community.

Whilst we support many of the initiatives described in the report, we have some specific feedback on the current and future contribution of the community mental health sector to the reform needed. We would like to see an investment in innovative community-based solutions to some of the gaps identified in the report, including the 'missing middle'. We would welcome investment in developing community-based solutions which take a broader view of wellness, making a fundamental shift to less restrictive alternatives to hospital-based care. This will require a strategy for training and skilling a workforce who can work alongside people, supporting them to make lasting connections in their local communities.

We are particularly concerned about investment in rural, remote and very remote regions of Queensland, and the need to ensure that people have access to high quality services wherever they live. QAMH is therefore supportive of any funding arrangements that commission services around the needs of individuals, families and local communities.

Finally, we would support an expansion of the Clinical Trials initiative described, to include the bringing together of expertise in lived experience, research, clinical and non-clinical sectors to develop a body of evidence informed treatment, care and support across the country.

QAMH is pleased to provide our feedback on the Draft Report.

Yours sincerely,

Jennifer Black
Chief Executive Officer

Contents

1.0 - The Queensland Context

Whilst our feedback on the draft report concentrates on a select number of areas, we have tried to capture feedback from the members of QAMH and reflect some demographics that are relevant to the landscape in Queensland. The state has historically spent less per capita on mental health services than many other states and territories.[1] Queensland had the second lowest spend per capita in 2015-16 and since 1992-93 has consistently spent lower on mental health services than the national average.[2] This is despite Queensland's population growth being above the national average, largely due to interstate and overseas migration.[3] It is therefore a culturally diverse state with more than 1 in 5 Queenslanders being born overseas and Aboriginal and Torres Strait Islander Queenslanders making up 4% of the population. In addition, 11% of the population identify as LGBTIQ+ and 18.3% are living with a disability.[4]

The Australian Bureau of Statistics (2018) reports that in 2017, Queensland suicide rates were higher than the national average with an upward trend occurring over the past decade.[5] It is the leading cause of death for Queenslanders between the ages of 15 and 44 and it is established that male suicide rates are higher in rural and remote areas which is specifically relevant to the geography of the state. [6] Queensland's Aboriginal and Torres Strait Islander suicide rate is double the general population and the number one cause of death in young Aboriginal and Torres Strait Islander Queenslanders aged 15 to 34.[7]

Queensland is the most decentralised state in the country, with rural and remote areas covering more than 95% of the State's land mass and home to over 1.65 million Queenslanders from a range of diverse backgrounds.[8] The decentralised nature of Queensland means that accessibility to mental health services is becoming a critical issue for suicide prevention and community wellbeing. Natural disaster, drought, reduced opportunity, and economic uncertainty continue to cause significant hardship for rural and remote communities.[9] With a diverse state, there are ongoing challenges in ensuring high quality service delivery to those who are most vulnerable and isolated within our communities.

Feedback from our community providers in rural, remote and very remote areas of Queensland, report significant service delivery challenges including:

- The need to manage acutely unwell people in the community, rather than facilitate an admission which would require significant travel and isolation from family and natural supports. Even if hospital care was considered more appropriate it can be difficult to source a bed in an alternative region; and
- The ability to find and maintain an appropriately skilled workforce to service rural, remote and very remote areas is a major problem. There is a high level of burnout in staff in these regions who often work in isolation without access to the training and development opportunities of their city counterparts; and
- Whilst telehealth has been part of the solution provided in rural and remote areas, it does not replace the human contact and relationships needed, to support people in distress to connect with natural supports within their communities. It has been plagued with problems like inconsistency in clinical staff and long wait times for appointments; and
- Whilst the element of choice has been the hallmark of the National Disability Insurance Scheme, the reality of this for rural, remote and very remote regions is that services are not there, and choice is simply not available. There needs to be solutions for both a clinical and non-clinical workforce in these communities to ensure access to specialist services.
- The use of the National Mental Health Services Planning Framework (NMHSP) to determine investment in rural, remote and very remote communities does not allow for the increase in service delivery costs.

Continued investment in all parts of the mental health system including early intervention in life and episode, suicide prevention and beyond the health system are welcome recommendations from the draft report. For Queensland it is important that services and supports are tailored to the unique demographics of the state, with a focus on government, local communities and other stakeholders working in partnership to promote wellbeing and co-design of local service systems.

2.0 - Community Mental Health Sector in the Report

Summary of Feedback

The Final Report should ensure that the unique contributions of the community mental health sector are clearly defined and distinguished from clinical services delivered in the community.

The report should:

1. Eliminate the confusion of terms used within the body of the report and clarify the distinctions between clinical community services managed by hospitals, and the community mental health sector.
2. Different states and territories use different language to describe similar programs, so a glossary of terms which provides definitions of the service sectors described in the report would be helpful.
3. Expand the description and acknowledgement of the current role and contribution of the community mental health sector throughout the continuum of care.
4. Strengthen the need for investment in innovative community-based solutions which would provide the fundamental reform alluded to within the report. This will require a change of attitude and focus, to design community solutions which support people to thrive rather than perpetuate illness focussed restrictive care.
5. An acknowledgement of the capacity, financial and workforce challenges of the community mental health sector, in a similar way to how the report has addressed these for other parts of the service system e.g. primary healthcare and acute care.

The Productivity Commission Draft Report has not adequately defined the community mental health sector, nor considered the current role or potential positioning of the sector to contribute to contemporary change in the future. The term "community mental health services" is used interchangeably throughout the report when referring to ''specialist community mental health services", "low intensity supports" and "psychosocial support". The report should distinguish the unique contribution of the community mental health sector from specialist clinical community mental health

services run by hospitals and primary healthcare. In addition, it should acknowledge that there are increasing examples within the community mental health sector, of integrated models and partnerships with hospitals and primary care, which could be considered "specialist community mental health services" in their own right.

The community mental health sector has traditionally worked closely with consumers, carers, GPs, hospital services, housing and education to address individual needs of particular communities.[10] It is an adaptive, versatile, and recovery-oriented sector, that uses consumer centred approaches to support people to live in the community and provides a welcome alternative to clinical or medical approaches for many people.

The report misses an opportunity to appropriately identify, define and address the capacity of the community mental health sector, and acknowledge its ability to respond to some of the gaps identified in the service system. The following section in our submission provides some advice to the Productivity Commission in helping define the sector.

3.0 - The Role of the Community Mental Health Sector

The community mental health sector consists of community managed and/or non-government mental health organisations who deliver a complex range of low intensity services, specialist services and psychosocial supports throughout the service system.[11] In the report, the role of psychosocial supports appears to be narrowly understood and as a consequence of the failure or limitation of clinical intervention:

"even with the best clinical treatment, episodic or persisting mental illness can result in the need for psychosocial and other supports…"[12]

Whilst the community mental health sector does provide psychosocial supports to post clinical episodes, it has a unique function, providing support and assistance in a holistic way to help people stay well and live contributing lives within their community. In addition, the core strength of the approach is its potential to minimise the need for hospital admission or clinical intervention, through proactive

management of mental illness and early identification of signs of deterioration. The community mental health sector is part of the continuum of community-based services which if properly researched and resourced, could provide a more economical support system alleviating the pressure at the clinical end of the system.[13] Its ability to comprehensively provide alternatives to hospital admission and presentation has been hampered by financial and investment limitations.

Examples of core services delivered by the community mental health sector include employment and education, leisure and recreation, self-help, peer support, online support, accommodation assistance, outreach support services, counselling, advocacy and more.[14]

> *"The NGOs provide a wide range of services and are often the best placed to provide essential links into the community and between services. They are to some extent the engine room of reform because of these links and because of their capacity to run flexible and consumer-centred care."*[15]
>
> - National Mental Health Council of Australia

It is generally accepted that the community managed mental health sector has been historically ill-defined due to the way it has grown and diversified to meet community need.[16] However, the community mental health sector has vast experience and a significant history of over 100 years in supporting recovery and social inclusion for people with a mental illness.[17] The Australian Government has undertaken some work to better understand the community mental health sector. The most recent data collected on our workforce, in 2015 *National Mental Health NGO Workforce Scoping Study* found that the size of the community managed mental health sector was approximately 800 organisations with a workforce ranging from 15,000-26,000 employees, and we imagine this has grown further in the last 5 years.[18] In the survey completed for the Scoping Study, 42% of respondent organisations identified that they had been delivering services for more than 20 years, 43% of respondent workers identified that they had health qualifications, and 34% of workers had vocational qualifications.[19]

In preparing this submission, QAMH sought feedback from our members on the unique contribution of the sector. Our sector is diverse and shaped to the needs of consumers and communities, as illustrated by some our members' statements about the role of their organisation:

> *"Primarily psycho-social in design, works with whole of person and meets them where they are at. Rather than specific symptoms of the illness, more about how those symptoms impact on the person's life. Holistic covering all elements of a person's life and understanding how mental ill health interplays with the other aspects e.g. housing, employment. Not symptom management but rather symptom management, strategies for wellbeing"* – **QAMH Member, NEAMI Australia.**[20]

> *"Stepping Stone offers a broad spectrum of services in a community-based setting. It is a peer led organisation that provides a non-clinical setting in the areas of prevocational, vocational, social, housing and health. It fills the gaps as it provides a purpose for people and keeps people out of hospital"* – **QAMH Member, Stepping Stone Clubhouse.**[21]

> *"GROW provides peer to peer group support where people build community, engage, belong and support each other. We also provide in-school services (Get Growing) for vulnerable students where they are helped to realise their personal value, that they are not alone in having problems, how to keep safe, how to support each other – again, building community within schools – and how to set goals and be resilient. We also provide eGrow services online, as well as services which support carers, and in prisons. Acute services do not do these things. Our services fill specific gaps with (a) groups of people supporting each other, having structure around their lives, and learning new leadership and friendship and (b) Get Growing goes beyond services such as Be You which simply provide learning opportunities and develops plans for teachers, to actually delivering face to face support services for students who have been identified as at risk. We also provide dual diagnosis residential support and recovery for people where the acute sector is not equipped to provide these services - indeed many services shy away from people with dual diagnosis."* – **QAMH Member, GROW Australia.**[22]

4.0 - The value of community-based care

Since deinstitutionalisation, advocates have called for contemporary, innovative solutions to long-standing problems within the mental health sector.[23] Over a decade ago, in 2006 the Australian Government noted that "*community based treatment has better health outcomes and less life disruption for the majority of individuals with acute and long-term mental illness.*"[24] The purpose of the National Mental Health Strategy was not only to shift services from institutions to local communities, but to recognise the need for less restrictive care and acknowledge the value of maintaining relationships with families, GPs, the NGO sector and local services like housing, general disability services, social security and employment.[25] Many organisations in the community mental health sector have developed programs on limited or short-term funding from multiple sources, which has limited their capacity not only to grow, but to provide stable and consistent programs, let alone evaluate and research the impact of interventions.

The consumer movement is now more than ever, demanding fundamental change from the historical illness saturated focus of clinical mental health care and is looking to Government reform to provide the impetus for this change.

5.0 - The Case for Major Reform

Summary of Feedback

Whilst QAMH welcomes many of the suggestions outlined in the report, the vision for fundamental reform is still unclear. We agree that it will take a holistic approach and a focus on the social determinants of health and reform beyond healthcare to achieve this but the mechanics of this needs to be planned.

The three overarching principles of the reform are commendable; that the system should be people-oriented and designed with and for people who use the system, have a focus on prevention and early intervention and be adequately funded. However, QAMH provides the following feedback:

- The report seems to have a clinical focus on community care when the commentary and experience of people who use the system, would point to the need for community supports which are less clinical and crisis driven, easy to navigate and flexible enough to dial up and down based on individual need and local demographics. It misses an opportunity to support significant investment in the fundamental redesign of community-based solutions to some of the issues identified in the mental health system.
- While we agree co-design is vital to ensure services meet the needs of those they are supporting, current practice is variable and at times resembles simple participation and/tokenism at worst. To ensure innovation, any service design strategy needs to embrace design thinking as a whole, bringing thinkers from outside the service system to create options for change. Co-design is just one stage in a larger design thinking piece, and we run the risk that if we only consult the stakeholders within the system, we lose the opportunity for real innovation and change.[26]
- In addition, we recommend that the final report should provide a clear and effective strategy for resourcing and building the capacity of the mental health system and local communities to implement and evaluate meaningful co-design practices.

QAMH welcomes the holistic approach taken by the Productivity Commission, in acknowledging the impact and social determinants of mental health. The Draft Report concedes that a failure to acknowledge these social determinants can result in an over-reliance on clinical services where other intervention may be more appropriate.[27]

Reform which is largely based on clinical services and medical based solutions to the issue of wellbeing, is narrow in focus. Despite modern Mental Health Acts being underpinned by human rights and recovery principles, including care being delivered in the least restrictive way, many consumers still describe hospital based care as traumatising.[28] Many of these negative experiences relate to seclusion and physical restraint, but women commonly experience sexual safety incidents in acute inpatient settings often leading to fear and re-traumatisation. The extent to which trauma informed care approaches have been embedded in services is limited and variable. [29]

The Productivity Commission has an opportunity to suggest reform which moves away from a model of wellness being measured by the absence or elimination of symptoms, to a framework which takes a broader view of wellness and makes a fundamental shift to less restrictive alternatives to hospital-based care. One framework for wellness is 'flourishing' which has been described in many different ways, but there is general agreement that it refers to doing well in the following domains; (i) happiness and life satisfaction, (ii) health both mental and physical, (iii) meaning and purpose, (iv) character and virtue and (v) close social relationships.[30] A community mental health approach based on wellness and/or flourishing type approaches, which works with individuals helping them form lasting connections within their local communities, is likely to be the most effective way of breaking the demand crisis seen in our hospital system.

We welcome strategies to create a people-oriented system where local communities are embraced as *partners* (not just a stakeholder) in service design and delivery, for their expertise in understanding the social and cultural needs of individuals living in their community.

We believe that consumer choice and access to evidence-based services are key in realising the goals of a consumer-oriented system. Mental health support is a complex matter and what works for one person may not be the approach for another, so the element of consumer choice is crucial for service redesign. We are mindful that for some people the coercive history of clinical mental health care, has created distrust and fear of hospital-based services, and subsequently they may choose not to seek further care.[31] A comprehensive flexible, community based mental health system can provide choice and alternatives to allow people to stay well in the community. In order to support this, there needs to be greater investment in services as well as research and evaluation of innovative models of care in the community.

Whilst QAMH supports co-design and co-production within service reform it does not go far enough to support the broader concept of design thinking of which co-design is one element. If innovation is the ambition of this reform, then the system needs to invite industries and creative thinkers beyond health into the design phase of the service system.

It should not be assumed that co-design is an existing skill within the sector, and the Productivity Commission report should acknowledge the need to support and develop the skills and expertise to

ensure that this is not a tokenistic exercise. The system needs to fund and support the development of local consumer and family/carer networks who can contribute meaningfully to this reform and work alongside government and service providers. Much has been written about the value of co-design[32] but the report needs to consider how consumers and carers will be valued for their expertise and knowledge, and what structures will support them to have equal power and influence in the mental health system.[33]

6.0 - Access, Navigation and Integration

Summary of Feedback

Whilst GPs are a crucial gateway for referral into psychological intervention through the current system of MBS rebates, we support initiatives to evaluate the evidence base to ensure this investment is adding the expected value in terms of early intervention.

In addition, there needs to be development of a range of alternatives to psychological therapies at the primary care end and across the stepped care continuum, which consider additional referral pathways for low intensity and psychosocial supports delivered within the community.

The focus of the primary care approach in the report is on psychological therapies through MBS rebates but if the system strives to encourage self-help seeking behaviours, early intervention approaches and alternatives to hospital and crisis based systems, it will need to consider a broad range of interventions that can be dialled up and down based on need and include low intensity and psychosocial support across the continuum. The model proposed in the draft report[34] is heavily reliant on people having to seek a medical response in order to get a referral, and on GPs having the knowledge of the mental health service system to make the referral across the stepped care model. A 'no wrong door' approach should include the ability to either self-refer or be referred by another agency for an assessment of need, without first having to seek a GP referral. There are many reasons, including financial, as to why an individual may not have a regular GP to serve this function.

Many community mental health organisations already operate low intensity services and psychosocial supports funded by local primary health networks (PHNs) or provide integrated models with clinical primary healthcare staff in community-based hubs. Expansion of theses may be one way of finding more innovative solutions.

QAMH supports the emphasis that the Draft Report gives to upskilling GPs, for their critical role in supporting people with a mental illness who have a higher risk of poor physical health outcomes.[35] We agree that further training and supervisory support for GPs is of benefit, for they are *often* the first point of call for an individual. However, a 'no wrong door' approach which supports referral from multiple community access points, would be preferable to being reliant on the person having a relationship with a GP clinic in order to navigate the system.

7.0 - Low intensity services

Summary of Feedback

QAMH proposes that the final report defines low intensity support more clearly and supports the further development of low intensity support models, but in doing so should address the following challenges:

1. **Referral Pathways:** where GPs are often a gateway for contact to appropriate services, GPs must be further educated on low intensity support options to best meet the needs of an individual; and
2. **Merits of low intensity support:** often low intensity support is described as a method of managing waitlists for psychological services, rather than being recognised for the positive outcomes that can be achieved through this approach.
3. **Explore additional models:** low intensity models which use recovery coaches who deliver a broad range of interventions and practical help in addition to psychological approaches.
4. **Workforce:** training and skill development.

QAMH supports the need for low intensity services as part of the stepped model of care and welcomes the recommendation that implementation is pursued by commissioning authorities.

In comparison to high intensity service delivery, low intensity intervention can produce the following outcomes:[36]

- Reduction in the amount of time the practitioner is in contact with the patient via seeing multiple individuals at one time, supporting individuals to make use of self-help material, facilitating engagement with community or voluntary resources, and fewer/shorter sessions.
- Practitioners are specifically trained to deliver low intensity interventions.
- Less resources are utilised.
- Rapid access to preventative and early intervention low intensity treatments, including the opportunity for self-referral.

We note the Productivity Commission's focus on the **NewAccess** model. NewAccess has a 67.5% recovery rate for participants, improved the quality of life for individuals who have recovered, and reduced the usage (and expenditure) on existing mental health services.[37] This is evidenced by:

- An engagement level of 35%-47% of male participants across three sites;[38]
- Successful implementation in rural New South Wales, where stakeholders unanimously agreed that access to mental health care improved with the introduction of NewAccess.[39]

Case Study: Provided by QAMH Member (NewAccess Provider)[40]

Sarah[41] is a 51-year-old female living with her husband and 2 young adult sons. She was employed full time and she referred herself after receiving a NewAccess flyer in the Post. Sarah identified as being "a bit of a perfectionist" and had recently had a negative experience at work which had involved another person and had increased her anxiety; she noticed that this sense of apprehension was impacting her both at work and at home. Sarah developed 2 goals to work towards: that in 6 weeks, she will be

worrying less and not feeling as much fear at the mention of the person involved in the uncomfortable situation and will enjoy her down time at home; and she will clear space to re-engage hobbies.

Sarah addressed this anxiety systematically through the coaching process, experimenting with testing her limits. Sarah experienced a genuine sense of freedom from worry through this experiment. She went on to bigger experiments and she began engaging in conversation more freely as she was not distracted by planning/worrying about what to say, she was addressing situations at home and at work that formerly she avoided due to being uncertain of the results or outcomes.

At the final session, Sarah was overjoyed to share with her coach that, on advice from her GP, she no longer required Blood Pressure medication as she has reduced her blood pressure to a healthy range. Sarah states that having good mental health impacts one's physical health as well. She stated she is sleeping better and consistently through the night whereas she previously would wake very early and worry about what the next day may hold.

There are several barriers that must be addressed for there to be effective implementation of any low intensity service delivery in Australia, whether this is NewAccess or alternative low intensity models. They are:

- **Workforce and models of care:** There are few studies on the competency and skill requirements for delivering low intensity CBT appropriately.[42] There must be further investment in workforce development to support a national low intensity service model, and a consideration of core competencies for this workforce. The exploration of the role of recovery coaches who can provide practical support in this low intensity space, should also be explored.
- **Referral Pathways:** Despite the ability of self-referral for low intensity, GPs often remain the *gateway* for help-seeking. One of our member organisations providing NewAccess reported difficulties with obtaining referrals from GPs, and that the onus remained on the provider to educate GPs about low intensity service options. If GPs are likely to continue to be a primary gateway to all stages of the stepped care model, a coordinated approach to GP education would

assist with increasing service volume and ensuring consumers are connected to services appropriate for their needs.

- **Merits of Low Intensity Intervention:** Often, low intensity services are viewed as an option for managing the waiting list of moderate psychological services. Low intensity services, like NewAccess, operate from existing service hubs to create partnerships and demonstrate their value as a legitimate service for meeting needs of consumers.

8.0 - The Missing Middle

Summary of Feedback

QAMH agrees that there are fundamental service gaps between primary and acute care and that people can easily fall through when they do not meet the criteria, or they choose to disengage from funded service streams.

If we are serious about fundamental reform and acknowledging that keeping people well in the community is a priority, then the answer to filling this gap is not a purely clinical one.

The report needs to recommend investment in the development of a flexible community mental health care model which includes but is not limited to the following principles:

- A variety of evidence-based treatments and supports which measure outcomes for the individual and achieve value for money for the community
- Least restrictive care in the local community is the preferred treatment modality with hospital admissions seen as a last resort
- Access to services is needs-based and responsive to changes in mental health status
- Developed through design thinking including co-design with consumers, carers and local communities
- Access to care respects choice and has multiple access points

- Has a strategy for the development of a community-based workforce that is knowledgeable about strength-based approaches, compassionate, culturally informed and competent in trauma-based approaches.
- Is integrated with other sectors to support community wellbeing
- Has consistent approaches to data collection and is supported to evaluate and research effectiveness
- Is based on human rights and has positive staff cultures that are free from discrimination and stigma.

We have been concerned for some time about people who are falling through the gaps which could be for the following reasons:

- Services are not meeting people's needs
- People are turned away or told they are ineligible for funded programs
- People are turned away from treatment, based on diagnosis or co-morbidity
- People experience hospital or clinical mental health care as traumatising or re-traumatising and choose not to seek further care
- People who experience vulnerability, like homelessness or difficulty advocating for themselves
- Complexity of navigating an NDIS package or ineligibility.

The missing middle has emerged due to increased demand in the system and a lack of community-based alternatives, leaving people to seek psychological therapies through GPs or attend hospital emergency departments when in crisis.[43]

The community mental health sector has been limited by funding structures and eligibility criteria through models such as low intensity or primary care services funded through PHNs, and funding for psychosocial support at the more acute end of the system. However, psychological interventions don't necessarily meet the needs of this group who are not severe enough for acute intervention. In order to address this, a service system needs to be developed which provides a range of alternatives which could be a combination of peer led supports, low intensity models, psychosocial supports and alternatives to hospital

admissions. There needs to be investment in developing a community mental health workforce capable of delivering evidence-based care in the local community, connecting the dots between the various service systems impacting on the wellbeing of the individual.

9.0 - Alternatives to hospital-based treatment

Summary of Feedback

We agree that there needs to be a refocus away from crisis driven systems, to provide alternatives to hospital-based treatment. The report should highlight some innovative programs and international approaches that already provide models for this.

Investment will be required to ensure innovation, evaluation and sustainability beyond trials. Some of these alternatives are being trialled in parts of Australia but on a small scale with limited investment, which may hamper progress and impact on the ability to realise the potential.

We support the Productivity Commission's focus on providing alternatives to hospital-based treatments:

'In addition to increasing the availability of the community mental health services, State and Territory Governments should aim to expand the range of alternatives to EDs for people experiencing mental illness.'[44]

The approach should target the expansion of community-based mental health supports as an economical method of early intervention and to prevent deterioration of mental health and actively support wellbeing. In addition, there should be development of a range of alternatives to emergency departments and inpatient admission. The feedback from consumers to the Productivity Commission has highlighted that people who use the system want investment in less restrictive options, which uphold their human rights and focus on citizenship.

The unsuitability of emergency departments is well documented with people experiencing them as noisy, stimulating, lacking privacy and with long wait times to access mental health assessments and/or beds where required.[45]

The report needs to address the need to resource, trial and research models locally or internationally, that have proved effective in providing safe alternatives.[46] Some examples of international models are the "Host Families Scheme" implemented in the UK, where guests are placed with a host family in a caring, family environment which focuses on daily routine and involvement in family and community life.[47] Another example is "the Living Room", emerging from the US where a non-clinical environment is established that takes the shape of a safe and familiar home environment for people experiencing crisis.[48]

There are some trials of "the Living Room" style alternative to ED presentation already underway in Australia. In Queensland, one of QAMH's Members, Brook RED, has developed an alternative model to hospital-based treatment and care, which is currently being evaluated:

Alternatives to Hospital-Based Care: Living EDge[49]

Traditionally, people experiencing suicidal distress find themselves referred to acute health settings that are not ideally suited to respond to their distress or in a timely way. Queensland Mental Health Alcohol and Other Drugs Branch (QMHAODB) has funded Brook RED to design and test a lived experience service for people presenting to acute settings in suicidal distress. **Living EDge** is a proof of concept program whose multi-pronged design offers both an alternative and adjunct to the emergency department as well access to short term individual and self-management supports. Its underpinning approach is more than traditional support provision and utilises lived experience curated opportunities so people can pivot their experiences of distress into wanting to live.

There are two main components of the Living EDge design:

(i) the Living EDge room that is a peer hosted cottage, on site at Redland Hospital, utilised by people who are either waiting for an assessment or are using the space to self-regulate their distress to avoid an ED presentation. From its inception in April 2019 to date over 170 people have accessed the Living EDge room, and

(ii) Living EDge in the community which provides short term, 1: 1 peer support follow up where people can more intentionally be supported and challenged to pivot their distress into wanting to live well.

10.0 - Integration and Care Coordination

Summary of Feedback

Whilst the notion of care-coordination for people with complex needs is fundamentally sound, it would need further exploration before investment and application.

The role of a care-coordinator is a skilled and complex one in mental health and reflection on the issues that have arisen through this model within the NDIS should be explored before implementation. Care coordination should be provided by a skilled workforce, imbedded in the community and should have the power and ability to influence across sectors to be effective.

In regional, remote and very remote areas of Queensland, where there are limited services, care coordination will be problematic before workforce availability issues have been considered.

The idea that care should be coordinated when the needs of the individual cross several jurisdictions and service types, seems sound to assist consumers with accessing the services best-suited to their needs.[50]

Within our sector, there is a commonly held view that the care coordination for NDIS has been problematic in the rollout. Care coordination for NDIS represented a viable option for aiding the individual in navigating services that best fit their needs, thus elevating choice as a key component of NDIS. However, this is reliant on the care coordinator knowledge of the services on offer and their ability to assess mental health needs and support someone to articulate their choice within this. This is a skilled role and the workforce available to fulfill this role needs further development. In addition, particularly in regional, remote and very remote areas of Queensland, where there are limited services, care coordination will be problematic before workforce availability issues have been considered.

11.0 - Mental Health Workforce

Recommendation

Apart from the inclusion of a peer workforce which our sector fully supports, the draft report largely takes a clinical approach to workforce shortages and omits a discussion about the potential to develop and build a community workforce for the reform required. The report omits a discussion about the current challenges to the community mental health sector in finding, developing and retaining a skilled workforce. The following feedback for inclusion is provided.

- Whilst we support better access to clinical services particularly in rural, remote and very remote regions in Queensland, the workforce required to meet the needs of the missing middle will largely need to be developed within the community sector. The report should outline a clear strategy for developing a recognised skill set and training to support the development of a skilled community workforce into the future
- A specific strategy will be needed for development of such a workforce in rural, remote and very remote areas.
- Development of the peer workforce including recognised training and career pathways, and provisions for supervision and support.
- A strategy for supporting diverse cultural and marginalised groups to develop relevant peer workforces.

11.1 - Community based workforce

We note that the section of the report which identifies the needs of the workforce does not take the opportunity to develop a community workforce to address the skills needed for the service system of the reform. Much more work needs to be done to explore innovations in service models and partnerships between sectors to create alternatives to ED presentation and hospital admission, as well as interventions that will meet the service gaps identified in the 'missing middle'.

Once the service system emerges through design thinking, there needs to be investment in a core skillset for a community-based workforce defined by the needs of the local communities and people who use the service system, rather than by the needs of the professions, the organisations in which they work and the health system.[51]

Whilst recommendations for increasing clinical workforce particularly in regional, remote and very remote locations are welcome, there are current workforce challenges for the community mental health sector that have not been addressed. Due to increased demand, community-based services are working with a greater complexity in presentation requiring a higher level of skill than previously. Whilst capacity could be developed, this is often developed internally by the organisations due to limited formal training opportunities for specialist skill development. We hear from our members that there is a high turnover of staff due to funding instability in the sector and there is a general lack of suitable staff available in rural, remote and very remote areas.

11.2 - Peer workforce

QAMH supports the inclusion of the peer workforce as a valued profession within the Draft Report, particularly the recommendations made to increase the peer workforce. However, we find the experience requirements listed for peer workers within the Draft Report does not acknowledge the complexity and skill required to be a peer worker. This is captured in the Draft Report by Table 11.1

Training Requirements for Selected Health Professionals[52]:

Profession	*Minimum Qualification*	*Minimum Duration*
Peer Workers	*Lived Experience of having a mental illness or being a carer*	---

Just having experience of mental illness, does not equip someone to support people in distress or prepare that worker to work within the mental health system, which may be re-traumatising or stigmatising. This simplistic approach does not reflect the value and expertise that the peer workforce brings, and the specialist skills required. Peer workers encourage individuals to define their needs, consider choices

available to them, and experiment with different strategies in a way that is recovery oriented.[53] The current emerging qualification for a peer worker is a Certificate IV in Mental Health Peer Work[54], and contains a number of core units including:

- Applying peer work practices in the mental health sector
- Contributing to continuous improvement of mental health services
- Applying lived experience in mental health peer work
- Working effectively in trauma informed care
- Promoting and facilitating self-advocacy
- Contributing to work health and safety processes.

In addition peer workers, like other staff, are often exposed to significant trauma and disclosures through their work, and currently there is no agreed standards for supervision and support in the workplace that would be important to consider in development of such a workforce.[55] The Draft Report should adequately consider the qualifications for a peer worker, and to canvas support that should be implemented to capacity-build the peer workforce.

11.3 - Rural, Remote and Very Remote Workforce

The importance of addressing the shortage of mental health workers whether they be clinical, community or peer workers is crucial in regional, remote and very remote Australia. We therefore welcome the Draft Report's focus on dealing with the geographical disparity of workforce for rural and remote mental health services. However, the recommendations (like telehealth services) for this are largely targeted at clinical health professionals—for example mental health nurses, GPs and psychiatrists.

Whilst technology can be useful and provide opportunity, this should not be viewed as a replacement (or, the solution) to filling workforce and service gaps in rural, remote and very remote areas. People in these communities have reported that face-to-face support continues to be the preferred mode of support and care, delivered by people who live in the community and can support people to access natural supports.

12.0 - Governance and Funding Arrangements

Summary of Feedback

QAMH is in support of funding arrangements that commission services around the needs of individuals, families and local communities. However, committing to a major structural funding reform prior to determining what the service system needs are, seems like an expensive bureaucratic exercise.

The risk of the rebuild model without first investing in service design and innovation to determine how to address the 'missing middle' and create a wellbeing model that relieves the pressure on the acute end of the system, could lead to the majority of resources being consumed by acute services.

A more pragmatic approach would be to renovate but have clear pathways and guidance for funders to work with communities to design, plan and commission services.

We welcome longer term contracts for funding to ensure greater stability of services and better continuity for people accessing the system.

Whichever funding arrangements are adopted there needs to be significant investment across the service system which is ringfenced to ensure that all parts of the system are funded adequately.

We note the proposed reforms to system and funding governance as proposed by the Productivity Commission and agree with the vision for creating funding to tailor services to meet the needs of consumers, carers and communities. Adequate funding remains a pain point for the whole service system from primary to tertiary care. First, we need to invest in determining what models best work across the continuum of care to address the gaps identified. We need a coordinated approach to research and evaluation of these models to determine whether they are achieving outcomes that are relevant to individuals and communities. We would welcome further investment in regional planning to build upon the work that has been achieved by PHNs in the primary care space, but which addresses the gaps identified in the moderate to severe end of the system.

There are some concerns about the recommended Regional Commissioning Authorities (RCAs) and the upheaval and infrastructure that would be required to do this when we are not yet clear how to address the gaps. One of the primary concerns is that this model may not change the cycle of funding going to acute clinical services, rather than less restrictive alternatives in the community. Whichever funding arrangements are adopted there needs to be significant investment across the service system which is ringfenced to ensure that all parts of the system are funded adequately.

We agree that some structural reform is necessary and that federal, state and territory governments should work together to reform the architecture of the system and clarify roles and responsibilities but we are yet to be convinced that the rebuild model will do this without adding an unnecessary layer of bureaucracy.

13.0 - A framework for monitoring, evaluation and research

Summary of Feedback

QAMH welcomes the recommendations for a data linkage strategy and to design fit for purpose data that should be collected to drive improved outcomes for consumers and carers. Too much of the current data is about throughput and compliance, so development of measures that reflect outcomes important to consumers and carers will be fundamental to shifting quality of care.

We note the recommendation for a clinical trials network but would recommend a model more like the one outlined in the Interim Report for the Royal Commission into Victoria's Mental Health System (November 2019).

'the creation of the Victorian Collaborative Centre for Mental Health and Wellbeing to bring together expertise in lived experience, research and clinical and non-clinical care, disseminating the practice of evidence-informed treatment, care and support across the state'

Our view is that this should be the national approach to research and evidence rather than a clinical trials base which is likely to be centred around medical based approaches.

QAMH welcomes the Productivity Commission's focus on monitoring, evaluation and research across the system. We believe that data evaluation and research are key to best practice in Australia's mental healthcare system. Funding should be allocated where there is strong evidence of outcomes,[56] but further work needs to be done to ensure that these outcomes are relevant to the individual and communities. This means greater investment in research and evaluation across the service system.

We note that the Productivity Commission has requested further information on why datasets are underutilised and the existing barriers—we are able to provide some context on these barriers within our sector.[57] Consistently, our members report that data collection and outcome measurements are crucial for building evidence-base but report a number of difficulties for achieving this. In response to our survey issued for feedback on the Productivity Commission's report, our members stated that:

> *"We strongly support the use of data and outcomes to inform both service delivery, design and review. Our contracts have an expectation of this but do not cover the associated costs. Organisations have had to employ staff to assist in this but funding contracts limit overhead costs and these are not considered part of the core service delivery"* – **QAMH Member, Aftercare.**[58]

> *"We can collect data from individual events. We currently rely heavily on effectiveness data from international studies and other Australian jurisdictions to develop programs designed for impact. Evaluation costs are not funded and are very expensive, longitudinal data even more so. The research evidence can be quite clear on what works, and it should be used more effectively before policy leading to tenders and programs are developed"* – **QAMH Member, Self Help Qld.**[59]

In 2018 QAMH conducted a survey of member organisations to understand current data collection practices, and the existing barriers for effective monitoring and evaluation of this data.[60] We noted that respondents identified lack of funding and resources to implement measures as the single largest barrier to effective implementation of outcome measurement frameworks, followed by access to aggregated data and lack of established methodology.[61] Our members also reported that outcomes are short-term and purpose built for justifying funding renewals—there is an absence of longevity in results where their intended purpose is to continue funding cycles, rather than to develop best practice standards for services.[62] .

We also raise some concerns about the Productivity Commission's recommendation for expanding research and best practice:

The Australian Government should fund the establishment of a national clinical trials network in mental health and suicide prevention. In developing this network, the Australian Government should consult with bodies that work in this area including the National Medical and Health Research Centre and the Australian Clinical Trials Alliance.[63]

This approach is likely to be medical in approach and miss the opportunity to research across the continuum of care and multiple service types.

In response to this, QAMH considers the recommendations flowing from the Victorian Royal Commission into Mental Health to be a strong mechanism for forming research that takes a whole-of-system approach.

> *"Service delivery alongside interdisciplinary research is important because it enables people with lived experience to participate in the design, development and production of research programs and reinforces the translation of research and evidence into high-quality care."*[64]
>
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