QUEENSLAND ALLIANCE FOR MENTAL HEALTH

WELLBEING FIRST

SECOND EDITION, NOVEMBER 2022

FIRST PUBLISHED JULY 2021

qamh
leading community mental wellbeing

Wellbeing First imagines a future state where everyone has access to locally designed wellbeing supports and where the nation's growth is measured not just in economic terms but also in its mental wellbeing.

QUEENSLAND ALLIANCE FOR MENTAL HEALTH

Queensland Alliance for Mental Health (QAMH) is the peak body for the Community Mental Wellbeing Sector in Queensland. We represent more than 100 organisations and stakeholders involved in the delivery of Community Mental Wellbeing Services across the state.

Our role is to reform, promote and drive community mental wellbeing service delivery for all Queenslanders, through our influence and collaboration with our members and strategic partners.

At a federal level, we collaborate with Community Mental Health Australia. We work alongside our members to add value to the sector and act as a strong advocate on issues that impact their operations in Queensland communities.

ACKNOWLEDGEMENTS

This report is informed by eight months of research and exploration. The research was led by CEO Jennifer Black with guidance from Jose Ramos (Action Foresight) and Helen Glover (Enlightened Consultants).

The work was supported by the staff of QAMH.

A range of workshops and consultations were held with QAMH members and key stakeholders across the mental health system within Queensland and across the nation. We thank all of those who participated.

AVAILABILITY

The report is available online at **www.qamh.org.au**

DISCLAIMER

The views or opinions in this report do not necessarily reflect all the stakeholders that were consulted during the life of the project.

Many of the service examples that have been showcased throughout the document have been chosen because their values and frameworks align with the vision articulated. QAMH has not formally evaluated the efficacy of these approaches but has provided references for the further interest of readers.

Every effort has been made to ensure this document is accurate, reliable, and up to date at the time of publication. QAMH does not accept any responsibility for loss caused by reliance on this information and makes no representation or warranty regarding the quality or appropriateness of the data or information.

QAMH CONTACT DETAILS

Address: 433 Logan Road, Stones Corner QLD 4120

For any further information please contact:

Jennifer Black
Chief Executive Officer
Email: jblack@qamh.org.au
Tel: (07) 3394 8480

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GLOSSARY

ACRONYMS:

QAMH	Queensland Alliance for Mental Health
CMHA	Community Mental Health Australia
ABS	Australian Bureau of Statistics
HHS	Hospital and Health Services
MBS	Medicare Benefit Schedule
NDIS	National Disability Insurance Scheme
LGBTIQ+	Lesbian, gay, bisexual, transgender, intersex, and queer/questioning, and the + represents other identities not captured in the letters of the acronym
PHN	Primary Health Network
MHCT	Mentally Health Cities Townsville
WHO	World Health Organisation

KEY TERMS	
Biomedical model	A model that emphasises medication-based treatments and monitoring to reduce mental illness symptoms.
Flourishing	A state of high wellbeing. Flourishing states have a high presence of psychological, emotional and social wellbeing indicators.
Languishing	A state of low wellbeing. Languishing states have low levels of emotional, social and psychological wellbeing indicators.
Person-centred	An approach that places the person experiencing mental ill-health at the centre of the service.
Person-led	An approach that responds to the person as the leader of their life in ways that foster personal agency and the capacity to manage challenges. Person-led approaches require providers to be accountable to the person.
Psychosocial supports	Individualised supports that create opportunities for people to better respond to their needs, such as social connection, relationships, self-care and economic participation. Also called “wellbeing supports” for the purposes of this report.

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JENNIFER BLACK

FROM THE CEO

Since the global pandemic hit, we have all been faced with significant disruption to our lives and a prolonged period of uncertainty. It has been a blow to the mental health of the nation.

For those of us who work in the mental health sector, it has once again shone light on a system desperately in need of change.

The pandemic came just after the release of the draft report of the Productivity Commission's Inquiry into Mental Health (2019). While there has been a plethora of reviews and reports over the past two decades, the Productivity Commission - the nation's key economic advisory body - confirmed that the mental health system is in crisis. Compellingly, it stated that "*the right services are often not available when needed, leading to wasted health resources and missed opportunities to improve lives".* At the beginning of 2020, a new Human Rights Act also came into force in Queensland and the idea that our system was failing to improve the lives of the people it was set up to help, was hard to absorb.

The Queensland Alliance for Mental Health (QAMH) is the peak body for community managed mental health organisations - those organisations that provide much practical support to people in mental distress in our community. During the pandemic, we witnessed a surging need for these services. In response, the sector rapidly developed innovative models of care, showing strength, resilience and agility.

It struck the QAMH team that this crisis could be the burning platform to finally effect real change in the system.

To this end, QAMH collaborated with futurist Jose Ramos (Action Foresight) and mental health innovator Helen Glover (Enlightened Consultants), to paint a vision for the future.

This vision is not a wish list, but the result of deep consideration by the members of QAMH and key representatives of the broader mental health system. You may notice this report refers to the community managed sector as the Community Mental Wellbeing Sector. This is deliberate, in that it underlines the unique contribution of the sector and the preferred change of direction articulated in this report.

Our preferred future has been formulated using strategic foresight thinking, processes and scanning mechanisms. It is set within the political, economic, social, technological, legal, and environmental horizons of the next five to ten years.

"Strategic foresight is the ability to create and sustain a variety of high-quality forward views and to apply emerging insights in organisationally useful ways."
(Slaughter, 2018, p 11)

We know integration within the system and across systems is crucial and that the Community Mental Wellbeing Sector needs to embrace its unique offering in the context of the broader system to be most effective. We also acknowledge that a range of responses will always be required to meet community needs. While the preferred future outlined in this report has been configured largely for the Community Mental Wellbeing Sector, we believe many of the ideas could have broader application.

Wellbeing First is a call to fundamentally shift the focus of our sector from managing illness to actively supporting wellbeing.

Jennifer Black

EXECUTIVE SUMMARY

This report examines the urgent and compelling need for change in the mental health system.

This is based on three key points:

- The current system has been repeatedly identified as one which is struggling with demand, fragmented, siloed and difficult for the public to navigate.
- This vexed system is now facing unprecedented pressure from the mental health impacts of the COVID-19 pandemic.
- Human distress does not always need a medical response. For this reason, we need to move beyond current models of care, and pivot to a contemporary whole of community approach that places *Wellbeing First*.

In this report, the Queensland Alliance for Mental Health (QAMH) calls for fundamental changes to the way we fund and position community mental wellbeing services in Queensland.

There are several clear reasons to do this:

- The Community Mental Wellbeing Sector is an under-utilised element of the mental health ecosystem with huge potential to provide a practical, early intervention approach.
- The pandemic has taught us that mental wellbeing supports are no longer considered relevant only to a small proportion of people living with disadvantage. There is growing demand to recognise them as economic, social and health necessities for everyone.
- For decades, people with lived experience have been calling for new approaches, and many report their most positive experiences have been with community mental wellbeing services.
- In this report, QAMH argues that only when a range of alternatives to medical intervention can be accessed, will the system be truly trauma informed and recovery oriented.

The vision outlined in *Wellbeing First* would have life-changing benefits.

For the individual, this approach will build social and economic participation. For clinical mental health services, it will alleviate many of the current demand pressures. It will increase community resilience to life challenges. And for the nation, it will foster mental wealth.

Mental wealth is defined as the collective cognitive and emotional resources of citizens. It includes people's mental capital, their mental health and wellbeing which underpins the ability to work productively, creatively and build and maintain strong positive relationships with others.

Wellbeing First imagines a future state where everyone has access to locally designed wellbeing supports and where the nation's growth is measured not just in economic terms but also in its mental wellbeing.

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PART 1:
THE MENTAL HEALTH CRISIS

KEY POINTS

- The COVID-19 pandemic has raised public discourse about the importance of mental wellbeing.
- The pandemic will have significant impacts on the mental health of a broad sweep of the population.
- The responses so far to the mental health crisis focus on acute treatment rather than mental wellbeing supports.
- People are demanding a different experience from mental health care.
- The Community Mental Wellbeing Sector is ready to provide broader mental wellbeing services.

The COVID-19 pandemic has significantly disrupted our lives, fundamentally changing the way we live, work, love, and play. For many people, the impact on their mental health has been significant and the notion of actively working on their own mental wellbeing has been a new experience.

Never have we seen such widespread public discourse about the importance of our mental wellbeing. The prevalence of diagnosed mental health issues such as depression and anxiety have been steadily increasing and COVID-19 has increased all the known risk factors. The enormity of the situation has identified the gaps in available supports, and highlighted the challenges for traditional mental health services to adapt to the rapidly changing needs of the population. There is an urgent and compelling need to change how we design, access, and provide mental wellbeing supports that are responsive and meet a whole of population need.

1.1 The current public mental health crisis

Our mental health models are principally designed to be reactive, crisis-driven and focus on those with severe and persistent mental ill health. Care is often experienced as coercive, traumatising or re-traumatising, creating unintended harm to those who most need help.

The mental health system is notoriously difficult for people to navigate, particularly when in distress, leaving no alternative but to go to a hospital emergency department. In 2018 the Australasian College of Emergency Medicine concluded that the current mental health system fails individuals, families, and health services, and that the strain on emergency departments as well as patients and families is unsustainable (Duggan, 2020). People with lived experience have outlined the distress of overcrowding, noise, long waits and the use of restrictive practices in emergency departments. Despite this, emergency departments are still the primary access point for people in distress and will remain so until sustainable community alternatives are established and supported.

Alarmingly, there is also a large number of people the Productivity Commission calls the 'missing middle'. This cohort is considered to be too unwell to be treated in the primary care system but are not deemed sick enough to be treated by acute services. They fall between the cracks of federal and state funding and cannot necessarily afford to access private support (Australia. Productivity Commission, 2020). Post COVID-19, they are likely to be left languishing in greater levels of distress. Even if the 'missing middle' are eventually found, it is likely to be through a medical model.

Although well intended, many community mental health services have simply transposed a biomedical model of care into community settings. The Community Mental Wellbeing Sector is well-placed to provide an alternative but is often limited by a lack of resources and by prescribed models of care designed to reduce the burden on the medical system.

The Existing Mental Health Ecosystem

Mental health services in Queensland are funded at both a federal level through primary care initiatives and the National Disability Insurance Scheme (NDIS), and at a state level by Queensland Health through the Hospital and Health Services (HHS) and community-based services. Additional services can be accessed through the private health system but primarily by those who can afford the out-of-pocket expenses.

Primary Care

Primary health services such as GPs, nurses and allied health professionals often act as the entry point into the mental health system and provide services to those not requiring emergency care. These may be people seeking help for the first time, receiving assistance for mild to moderate mental illness, or managing their serious mental health issues with support.

Funding primarily comes from the Federal Government through Medicare rebates and at a local level through the Primary Health Networks (PHNs), which have a major role in developing and commissioning a range of mental health and suicide prevention services within their local regions.

Most primary mental health care is provided by GPs and the most common intervention is medication. In 2019-20 there were 40.7 million mental health-related prescriptions provided to 4.4 million people, with an average of nine prescriptions per person (Australia. Australian Institute of Health and Welfare, 2021). In the preceding year, 1.3 million people received MBS-rebated psychological therapy and the PHNs commissioned 70,000 sessions. 60,000 young people received help through headspace centres and about 4,000 used supported online treatment (Australia. Productivity Commission, 2020).

In addition to these services, there are a range of online and telephone-based supports, for example: Lifeline, Kids Helpline, Sane Australia Helpline, Beyond Blue, Parent line, PANDA and Diverse Voices.

Hospital-Based Care and Specialist Mental Health Services

The state funds specialist mental health services or clinical services, either as outpatient or residential and bed-based acute services. These are provided by the HHS and are designed to provide support to those with a more severe or complex mental illness or those in crisis.

...Continued from previous page

The 1300 MH Call access line is another key entry point into public mental health services. This mental health telephone triage service: "can provide support, information, advice and referral; provide advice and information in a mental health emergency or crisis; is staffed by trained and experienced professional mental health clinicians; will provide a mental health triage and refer to acute care teams where appropriate" (Queensland Government, 2020).

Emergency Care

The entry point into the clinical mental health system is often through hospital emergency departments. Due to the lack of alternatives available in the community, people in crisis either turn up themselves or are brought in by emergency services and the police. There are some interesting programs, providing community triaging points with an element of lived experience, but they generally lack the resources to provide effective 24-hour assistance. In Queensland there are eight new crisis support spaces being trialled which are in various stages of development.

Psychosocial Programs

The non-government or not-for-profit sector, supported by a mix of state and federal funding, has been the main source of psychosocial services in Queensland.

However, the psychosocial support landscape shifted significantly with the introduction of the NDIS. The NDIS now funds support for thousands of people who have a significant psychosocial disability through individual support packages. NDIS statistics indicate that in the July to September 2020 quarter, there were 7,067 participants with psychosocial disability in Queensland, who had an individually funded plan under the NDIS (NDIS, 2020). Since its introduction, the scheme has been criticised about its accessibility and its ability to respond to participants with mental illness.

The Queensland Government continues to fund other local supports through the non-government sector. Many of these operate in conjunction with clinical services and often require a clinical referral. This means they are not readily available to the public as an early intervention or self-management option.

1.2 The impacts of COVID-19

The problems of the system are not new, but the pandemic has amplified them. The full impacts of COVID-19 have not yet been realised and are difficult to predict. What we do know is that the psychological distress is widespread, stemming largely from the immediate impacts of the virus and the consequences of physical isolation and separation from and/or death of loved ones. In addition, many people have lost or are at risk of losing their income and livelihoods, creating uncertainty about the future. We know that there is strong evidence that employment has a positive relationship with mental health and that with every 1 per cent increase in unemployment, there is a comparable increase in suicide rates (Christensen, 2020).

Forecasting the lasting impacts on the nation's mental health is particularly challenging without knowing the duration of the pandemic, and without any similar scenarios to draw upon. What is clear, is that in the long term there is likely to be a significant increase in the number and severity of mental health issues requiring a response from the mental health system.

The Black Dog Institute reports up to a 40 per cent increase in calls to support lines like Beyond Blue and Lifeline and online supports. In a recent Australian study 78 per cent of respondents indicated their mental health had worsened since the beginning of the pandemic, with a significant impact on the mental health of those with a pre-existing mental health issue.

Given that loneliness, social isolation, and financial stress are significant risk factors for mental distress and suicidal ideation, it is particularly concerning that 80 per cent of people have reported moderate to extreme loneliness and worries about finances (Newby, 2020). The onset of COVID-19 has also led to an increase in alcohol consumption with 55 per cent of Australians reported to be drinking at levels hazardous to their health (Christensen, 2020).

In the past year, investment into acute mental health services has increased to deal with surging demand, suggesting more people are asking for help for the first time. In its December 2020 budget, the Queensland Government allocated an extra $743,488 million to the state's health budget. The detail of this was closely linked to hospital demand with the announcement of new hospitals, ambulance stations and health facilities.

The demand has come from a broad sweep of the community.

Emotional difficulties among children and young people have been exacerbated by increasing stress and anxiety, including within their families. The pandemic has led to social isolation, more family violence and disrupted schooling at critical points in the emotional development of young people. Research from *headspace* indicates 74 per cent of young people have experienced poorer mental health than before the pandemic. Many feel that COVID-19 has had an adverse impact on their confidence in achieving future goals. Interestingly, their most frequently used coping strategy has been talking to family and a reliance on natural supports (*headspace*, 2020).

The mental health impacts experienced by women are expected to be harsh, judging by employment figures alone. Almost 200,000 women have lost their jobs and 110,000 have left the workforce altogether since March 2020. At the peak of the COVID-19 restrictions more than one million women had no work at all. Women in the workforce are more likely to be doing most childcare and household work, as well as home schooling during lockdowns (Christensen, 2020).

Australian Bureau of Statistics data released in May 2020 suggested that 76 per cent of Australians with children in their household kept them at home during that period. In order to care for their children 38 per cent of people worked from home, 22 per cent worked reduced hours or changed their working hours and 13 per cent took leave (Australia. Australian Bureau of Statistics, 2020). The added stress within relationships and the restrictions on movement has correlated with a 30 per cent increase in violence towards women, adding yet another level of consequence to the public health actions (Christensen, 2020).

Older people are also at increased risk not only from the life-threatening complications of COVID-19 but also from the stress of accessing care for other physical and mental health issues. Loneliness is a major risk factor for mortality in older adults and they are more likely to be impacted by social isolation while physical restrictions are in place.

The health workforce is likely to be adversely affected by the stress of heavier workloads, the risks of becoming infected, of passing the infection to their own families and communities, as well as observing higher rates of death in their care.

The economic fallout is also likely to exacerbate existing health care disparities. This will result in a disproportionate impact on those already socially disadvantaged including those living with serious mental illness, disabilities, Aboriginal and Torres Strait Islander people, the LGBTIQ+ community and those from culturally diverse backgrounds.

In Queensland, there are additional difficulties associated with the state's size and geographical diversity. In regional and remote areas, the known risk factors include isolation as well as recurring natural disasters such as bushfires, floods, and drought. Very few mental health services are available, leading to long waiting times and significant travel to receive treatment. Sadly, suicide rates in very remote regions are more than twice the national average (Australia. Australian Institute of Health and Welfare, 2021).

In 2019, suicide rates in Queensland were significantly higher than the national average (Australia. Australian Bureau of Statistics, 2020). It is the primary cause of death in Queenslanders aged between 15 and 44 and the rate of suicide in Queensland's Aboriginal and Torres Strait Islander population is double that of the general population (Queensland Mental Health Commission, 2019).

Without timely and active responses to distress the rates of mental illness and suicide will inevitably rise.

1.3 The response required

This widespread impact has prompted demands for more help across the population. This requires a whole of government approach to put the mental wealth of the nation at the forefront of all decision making.

There is a better way to provide mental health care in the community.

In September 2020, QAMH consulted key stakeholders including CEOs of prominent mental health organisations. There was consensus that not all distress needs a medical intervention.

We know that the most successful public health strategies in times of crisis have been highly practical in nature, as exemplified by responses to various natural disasters. The Community Mental Wellbeing Sector is ready to deliver practical support in this crisis.

With a philosophy and approach that focusses on wellbeing rather than illness, community organisations could support people experiencing mental health difficulties before they reach crisis point, early in the trajectory of their distress. Access points and entry pathways to these mental wellbeing supports away from clinical gateways must also be created.

For the individual, early intervention will build social and economic participation. For communities, it will increase resilience to common life challenges. For clinical mental health services, it will alleviate many of the current demand pressures. And for the nation, it will foster mental wealth.

Governments around the globe are considering ways to foster mental wealth, in part prompted by the effects of the pandemic. The final report from the Productivity Commission Mental Health Inquiry outlined an economic argument for investment in the mental wellbeing of the nation (Australia. Productivity Commission, 2020). It found the economic benefits from following its recommendations would amount to as much as $18 billion a year.

Prioritising mental wealth would reap significant economic and societal rewards. But it requires investment in the mental wellbeing of everyone – a whole of population wellbeing approach.

Individual Benefits

- Improved mental wellbeing due to earlier intervention
- Increased satisfaction that services can respond to needs
- Decreased friction points to access support

Community Benefits

- Increased community mental wellbeing and mental wealth
- Increased economic engagement and productivity
- Increased liveability
- Access to services are normalised and encouraged, helping to reduce stigma
- Increased levels of community access, engagement, and participation
- Meet community expectations of accessibility and locally designed initiatives

Mental Health Ecosystem Benefits

- Reduced demand on emergency departments and acute bed-based services
- Reduced need for more expensive crisis intervention responses
- Reduced number of people using the Hospital System to access support
- Reduced demand on assessment and treatment services
- Free up space within clinical systems of care to focus on those that require clinical interventions
- Reduced number of referrals from clinical to community mental wellbeing services
- Improved clarity about the unique contribution of the Community Mental Wellbeing Sector
- Reduced duplication and competition between services

Mentally Healthy City Townsville

Townsville was the first city in Australia to take up the Mentally Healthy Cities challenge to support population-wide wellbeing. Mentally Health Cities Townsville (MHCT) is auspiced by the Tropical Brain & Mind Foundation to take action to support the communities within the Townsville City Council area to achieve a balance of mental health and wellbeing that enables our citizens to cope with the normal stresses of life, realise their abilities, participate in, and belong to community, and work productively. MHCT engages with the Townsville City Council, Townsville Hospital and Health Service, the MHCT Champions, the corporate and business sectors, community mental health sector and broader community groups to build local wellbeing capacity to create, improve and grow community resources. The MHCT website offers information about local mental health and wellbeing supports, including online sites and apps. Similar approaches have been successfully implemented in London and Philadelphia.

Find out more:

www.mentallyhealthycitytownsville.com.au

Mentally Healthy City Townsville™

PART 2:
THE ARGUMENT FOR CHANGE

KEY POINTS

- Despite multiple calls for change in the mental health ecosystem, there has been no significant reform
- The system is fragmented, siloed, difficult to navigate and designed to gatekeep demand for clinical resources
- A focus on early care in an episode or illness is crucial to ease the pressure on acute services
- Poor mental health has broad economic costs
- The Community Mental Wellbeing Sector can foster wellbeing outcomes that help build the mental wealth of the nation

2.1 Personal experience and outcomes

For decades, the voice of lived experience has told us they want services that help them stay well and regain control of their lives. The voice of lived experience has driven much of the contemporary reform agenda, articulating the need for a focus on mental wellbeing, greater self-determination and less restrictive care.

People with lived experience of care have described a system which is coercive and entrenched in a culture of discrimination leading to stigmatised responses from health care professionals. This implicit discrimination leads to low expectations placed on those accessing services and dependence on the system, limiting their own ability to manage distress, drive their care, and lead contributing lives (Carrotte, 2019; Edwards, 2017). People with lived experience have detailed the power imbalance in the current mental health system; how they have limited choice and control of their own treatment; how that treatment relies heavily on medication to alleviate distress, but which, in some cases, impairs their quality of life.

Alarmingly, at a time when there is emerging discourse around the protection of human rights, the mental health system has been described by the very people who seek help within it as traumatising and retraumatising.

The Community Mental Wellbeing Sector has provided a welcome point of difference. People with lived experience of our sector, often report their best experiences as those which challenge them to try new things, learn new skills and engage in full community life (Biringer, 2017; Myers et al., 2016). Services that adapt to meet the needs of participants rather than offering a one-size-fits-all approach can achieve even greater results.

The Community Mental Wellbeing Sector would benefit by continuing to challenge itself to work with people in different ways and ensure its workforce is equipped to help individuals drive their own care and outcomes.

Gift of Gallang

The Gift of Gallang 'Healing of the Mind, Body & Spirit' is a suicide prevention school-based program specifically developed for Aboriginal and Torres Strait Islander children in Brisbane's Inala region (grades 4-6). The program is also currently delivered in the Logan and Beaudesert regions.

The program aims to provide children with tools to support and nurture their resilience while providing a safe environment. Its development was prompted by several deaths by suicide of Aboriginal and Torres Strait Islander children and young people in the community. The community recognised the significant impact of these deaths on the well-being of individuals, families and communities.

Children are immersed in cultural age-old traditional ceremonies, practices and spirituality to strengthen their identity and give them a sense of belonging and connection. These are seen as crucial factors in enabling the children to weather obstacles and adversity in life. Children are provided and taught strategies using different mediums to manage their own social and emotional wellbeing. Aboriginal and Torres Strait Islander members of the community or those with strong cultural ties to the area facilitate the 11-14 week program, with a psychologist attached to each week's session. The program was developed by Mission Australia's Cultural Connect worker Roxanne Ware, a Bundjalung woman of Northern NSW, who was born and raised in the community of Inala. Ms Ware consulted with community, key indigenous organisations, and experts over a three-year period. The Gift of Gallang is community-driven, developed and owned by the Aboriginal and Torres Strait Islander community. Training was also undertaken to ensure the appropriate and sensitive components of the program would meet the needs of young ones and youth, delivering the core message of healing and resilience.

Find out more:

www.facebook.com/434251400094091/videos/904179850055259/

www.missionaustralia.com.au/publications/research/children-and-families

The program aims to provide children with tools to support and nurture their resilience while providing a safe environment.

2.2 The Economics of mental wealth

Poor mental health has economic consequences beyond health care, with costs incurred in the justice system, aged care, housing, and education.

The Productivity Commission indicated that 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 direct expenditure of $16 billion on mental health care, calculating the annual cost of lower economic participation and lost productivity at $39 billion and $15 billion in replacing the support provided by family and/or friends. It went on to say that 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 (Australia. Productivity Commission, 2020). These numbers make a compelling economic argument for change.

Between November 2006 and June 30, 2019, general practitioners wrote 31 million mental health care plans costing $2.75 billion, clinical psychologists provided sessions costing $2.45 billion and registered psychologists provided sessions costing $2.6 billion (Rosenberg, 2020). These figures would be far greater if all those who needed these services could afford them and were able to access them. Even so, there is little evidence to suggest this investment has decreased the prevalence of mental illness.

The system is costly for the taxpayer and simply not producing the outcomes desired for the health and wellbeing of the nation. Many countries, such as the United Kingdom and New Zealand, have begun to realise the impact of mental wellbeing on the economy and are moving to a policy language which articulates the value of mental wealth and a stronger emphasis on early intervention in both life and episode or illness (New Zealand. Ministry of Health, 2020).

Given we know that one in five Australians already experience mental ill health in any given year (Australia. Department of Health, 2021), we can safely assume that this ratio will increase the longer the pandemic continues. A response which simply strives to get more people into face-to-face care with health professionals is expensive and not necessarily accessible, relevant, responsive, or effective.

2.3 Reduce the burden on acute services

The mental health ecosystem is designed to respond to the impacts of mental illness, and the most resource intensive systems of care are in the crisis space. While there is widely accepted evidence that early intervention is the way of the future, much of the focus to date has been on early intervention in life, rather than early intervention in illness or episode. This means the system has been geared towards acute care providing mainly biomedical solutions.

It is well recognised that busy emergency departments are over-stimulating and unsuitable environments for people in mental distress, but, without realistic alternatives, they remain the primary entry point for receiving care (Duggan, 2020). Mental health presentations to emergency departments have increased by 70% over the past 15 years (Commonwealth of Australia, 2020). The acute system is consequently struggling with demand. The hospital has to act as gatekeeper of its limited resources and many are left without care. Those who do make it through the doors are at greater risk of untimely or unplanned discharge and relapse, subsequently increasing hospital readmission rates.

There must be a pivot towards mental wellbeing.

The Community Mental Wellbeing Sector could play a crucial role in reducing this burden on the acute system, by delivering services which focus on mental wellbeing and flourishing and provide active intervention early in an episode of mental distress. This will provide better outcomes for the individual and provide alternative avenues for help other than the local hospital emergency department. We are not suggesting that there is no need for acute services. But enlisting the Community Mental Wellbeing Sector to provide early interventions would enable acute services to concentrate on those who absolutely require them.

This is a considered economic and wellbeing strategy to provide the right resources, at the right time in the right place.

2.4 Culture and stigma

The overwhelming barrier to change within the mental health ecosystem is its own culture. Culture is formed by the explicit and implicit values and customs of how we collectively do things. The mental health system's culture is the 'elephant in the room' when examining the failure to embrace reform.

The current culture stems from a paternalistic model of caring which ultimately values the expertise of the clinical professional over the experience of the person living with an illness. People with lived experience of the system talk about a culture that promotes fear and powerlessness and low expectations placed on their recovery.

A similar power imbalance is experienced by different services in the mental health ecosystem, stemming from entrenched beliefs about what different parts of the system can and should contribute. For the Community Mental Wellbeing Sector, there are low expectations from other elements of the system of its professionalism and ability to manage risk and support complexity. This is due to its evolution and limited resources, and despite the positive outcomes being achieved by many community services.

2.5 Limitations of the current mental health ecosystem

Many of the reports into the mental health system in Australia describe a system which is fragmented, siloed, difficult for the public to navigate and designed to gatekeep the limited resources at the clinical end.

Many people in distress miss out entirely. Those who do not meet the entry criteria for accessing state funded mental health services or the NDIS but require more support than can be accessed through a GP or PHN, are often referred to as the "missing middle".

The Productivity Commission estimated a staggering 690,000 people would likely benefit from access to psychosocial support services if they were available. However, only 34,000 people currently receive NDIS psychosocial support (which is only just over 50% of those expected to be eligible when the scheme is fully rolled out). In addition, 75,000 people receive support directly from other government-funded programs. The gap is massive. The report also acknowledged that many others without a formal diagnosis may benefit from psychosocial support but would currently need to enter a medical pathway to receive any. It surmised that as many as one million Australians are missing out (Australia. Productivity Commission, 2020).

Despite the significant efforts of PHNs to promote a mix of community services to people, they are regularly undersubscribed. Activities include peer support and services with a focus on building resilience and mental wellbeing. However, one of the most difficult challenges for these services is a lack of awareness and recognition of the value of these supports by GPs. The Productivity Commission states that it is common practice for GPs in Australia to prescribe medication for mental distress (Australia. Productivity Commission, 2020). Referral to existing services is limited and when they do, they continue to refer people to clinical supports. This is through a Mental Health Care Plan for people to access Medicare-funded clinical

services, though most will be required to pay a “gap”. This “gap” payment can sometimes mean the difference between receiving help and languishing without.

Despite many reports articulating the need for person-centred care, there is still limited focus on personal recovery and wellbeing models with early intervention at the episode or illness level. Trauma-informed care and recovery-oriented practice are widely used concepts that describe a human centred way to work with individuals in distress. But despite pockets of good practice, the reality is that the change in language has not deeply altered the methods in practice. Many people still report experiencing care as coercive and traumatising or retraumatising.

2.6 The identity of the Community Mental Wellbeing Sector

The Community Mental Wellbeing Sector has largely emerged and grown in response to the high demands placed on acute services. It has been funded primarily to provide aftercare to people diagnosed with a moderate to severe mental illness with a focus on preventing relapse or readmission.

An artificial tension has developed between clinical and non-clinical settings, with an historical misconception that the Community Mental Wellbeing Sector can provide support only under the guidance of clinical services. This keeps the Community Mental Wellbeing Sector firmly in the realm of managing illness rather than supporting mental wellbeing. The sector also suffers from limited funding and short funding cycles, creating barriers to attracting, retaining and developing a skilled workforce. Despite this, some services have shown expertise in providing clinical services themselves – and often with a mental wellbeing and early intervention framework.

The public knows very little about the Community Mental Wellbeing Sector. Most mistakenly believe community mental health care is actually private therapy accessed through a GP. The public is largely unaware about the support that could be provided by the Community Mental Wellbeing Sector and is therefore unable to advocate effectively for this.

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 inconsistent expectations of what the sector and its workforce can deliver. As such, the specialisation and unique contribution of the Community Mental Wellbeing Sector to individuals, communities and the wider mental health ecosystem is not well articulated and undoubtedly underutilised.

Traditionally, 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 developed models based on consultation with participants.

Momentum Mental Health

Momentum Mental Health provides a supportive environment for its members to develop valuable life skills and receive mental health support. Previously known as Toowoomba Clubhouse, the organisation was established over 25 years ago, after its founders noted a shortage of community-based assistance for those living with a mental illness in the area. CEO Deborah Bailey describes the service as “not your typical mental health service” as it offers one-on-one coaching in vivo — that is, the coaching happens wherever in the community the individual experiences the barrier or boulder.

The change in name to Momentum Mental Health mid-2021 coincided with significant changes to how support is offered to participants. One change that has won strong community backing is that Momentum Mental Health no longer requires a diagnosis to access its services. “If someone wants to work on their mental health and they can access the service how it’s intended, they are welcome,” said Deborah. Another change is that participants will set out their goal on entry, plan how they want to achieve it, how they will celebrate when they reach their goal, and what their situation will look like when they are ready to exit the service.

During their time with Momentum Mental Health, participants are coached, either online, over the phone or in person. Among the many group activities and programs participants can join, are sessions which offer practical help with budgeting, sleep hygiene and exercise, and a Job Club. Momentum takes a collaborative, inclusive approach, ensuring there is less of a power imbalance than in most traditional mental health services. It also uses a number of methods to receive feedback from members, using that feedback to ensure Momentum remains relevant in its community.

Find out more:
www.momentummentalhealth.com.au

momentum
MENTAL HEALTH

2.7 The challenge of actioning reform

Why have we been unable to effect the change recommended by multiple inquiries? Unfortunately, the system is stuck in a cycle, holding on to the core belief that medical intervention is the main solution to the problem. While medical responses can be valuable for many, it is not the only strategy to manage distress and mental wellbeing.

There is a myth that drives many change initiatives into the ground: that the organisation needs to change because it is broken. The reality is that any social system is the way it is because the people in that system (at least those individuals and factions with the most leverage) want it that way. In that sense, on the whole, on balance, the system is working fine, even though it may appear to be dysfunctional in some respects to some members and outside observers, and even though it faces danger just over the horizon. There is no such thinking as a dysfunctional organisation because every organisation is perfectly aligned to achieve the results it currently gets (Heifetz, 2009).

The Productivity Commission acknowledges the findings of its report are not new and that many reform documents release earlier have failed to trigger change. The publication Croakey provides an insight into the system's stagnation, stating that there is 30 years of evidence that official inquiries into mental health have rarely led to major change; there were 32 of these reports between 2006 and 2012 alone (Doggett, 2020).

The Productivity Commission suggests that its recommendations would address cultural barriers to change.

However, the reality is that enacting the recommendations would require shifting resources from acute care to alternative co-designed models. This would be expensive in the short term, until the value of these alternatives could be evaluated and proven. To date, it has seemed cheaper and easier to tweak the current system or invest in more of the same.

There is a role for a range of services to make up the mental health ecosystem. Providing practical early intervention responses early in distress, would allow the more expensive medical interventions to be used where they are most needed and most effective.

Human distress does not always need a medical response.

PART 3:
EMERGING OPPORTUNITIES FOR THE COMMUNITY MENTAL WELLBEING SECTOR

KEY POINTS

- Focus on the sector's ability to contribute to Queensland's mental wealth
- Pivot to a mental wellbeing framework acknowledging the mental wellbeing continuum
- Develop prevention and early intervention frameworks to become the main entry point to the system
- Further embrace technology to expand service reach and reduce stigma

3.1 A focus on mental wealth

Mental wealth is an emerging concept that is gaining traction across Australia and the world. Nations have been challenged to use mental wealth as an indicator of economic and social prosperity (Beddington, 2008). The economic benefits of pursuing policies that are driven by mental wellbeing include increased individual productivity, reduced mental illness related Disability Adjusted Life Years[1], increased economic security, greater economic prosperity, and increased collective community resilience. It is only through harnessing citizens' cognitive resources that nations will prosper both economically and socially. Early interventions are key to this endeavour.

A nation's mental wealth is defined as the collective cognitive and emotional resources of citizens. It includes people's mental capital, their mental health and wellbeing which underpins the ability to work productively, creatively and build and maintain strong positive relationships with others.

How a nation nurtures mental capital, mental health and wellbeing, through adequate education, economic security, housing, healthcare, psychological and cultural safety, and through equal access to opportunity, will have a significant effect on its economic competitiveness and prosperity, and the collective wellbeing and resilience of communities.

[1]One Disability Adjusted Life Year represents the loss of the equivalent of one year of full health (WHO, 2000).

3.2 Pivot from managing mental illness to actively supporting mental wellbeing

The United Nations has called for countries around the world to use the current focus on mental health to propel reforms that finally shift care away from institutions towards a community approach. The United Nations says resources should be made available for community-based initiatives to activate and strengthen local and natural supports and encourage a spirit of community self-help. (United Nations, 2020).

This time of crisis represents an opportunity for community-managed mental health services to embrace a mental wellbeing approach. This would provide a distinct yet complementary response to the crisis, that would also be sustainable.

Now is the time to finally redesign the system, with a real understanding that responding to mental illness does not automatically create states of mental wellbeing.

Mental wellbeing can only be achieved within an ecosystem, that is underpinned by a flourishing framework responsive to all levels of human distress. Three critical and central tenets are necessary to guide the design and delivery of contemporary community mental wellbeing programs; (i) wellbeing opportunities, (ii) strengthening capacity to function well, and (iii) promoting community wellbeing (Westerhof & Keyes, 2010).

The terms ‘mental illness’, ‘mental health’ and ‘mental wellbeing’ are used interchangeably but they are significantly different constructs. The World Health Organisation (WHO) declares mental health as, “a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2004). A mental illness is a health problem that significantly affects how a person feels, thinks, behaves, and interacts with others. It is also diagnosed according to standardised criteria (Australia. Department of Health, 2021).

The mixed language often places mental wellbeing and mental illness opposite each other on a single continuum. However, good mental health or mental wellbeing is not simply the absence of mental illness and is not necessarily achieved through the treatment of mental illness alone.

The Mental Wellbeing Continuum

Mental wellbeing and mental ill-health are two different constructs, which move along two discrete but related continuums with clear valid indicators articulating their differences (Keyes, 2005).

At any given time, you can have:

- Low, moderate, or high levels of mental wellbeing, **AND**
- None, some, or all the symptoms of a particular mental illness.

Mental wellbeing exists on a continuum, ranging from floundering to flourishing [Figure 1]. A dual focus on both the mental illness continuum and the wellbeing continuum will ultimately provide the best outcomes. The mental illness continuum requires the expertise of the clinical sector, while the Community Mental Wellbeing Sector provides the expertise along the mental wellbeing continuum.

The impact of languishing or poor mental wellbeing is as expensive and detrimental as the experience of serious mental illness. Keyes (2005) stresses that only 20 per cent of the population experience states of flourishing at any one time, making early intervention key to improving quality of life and economic and social participation.

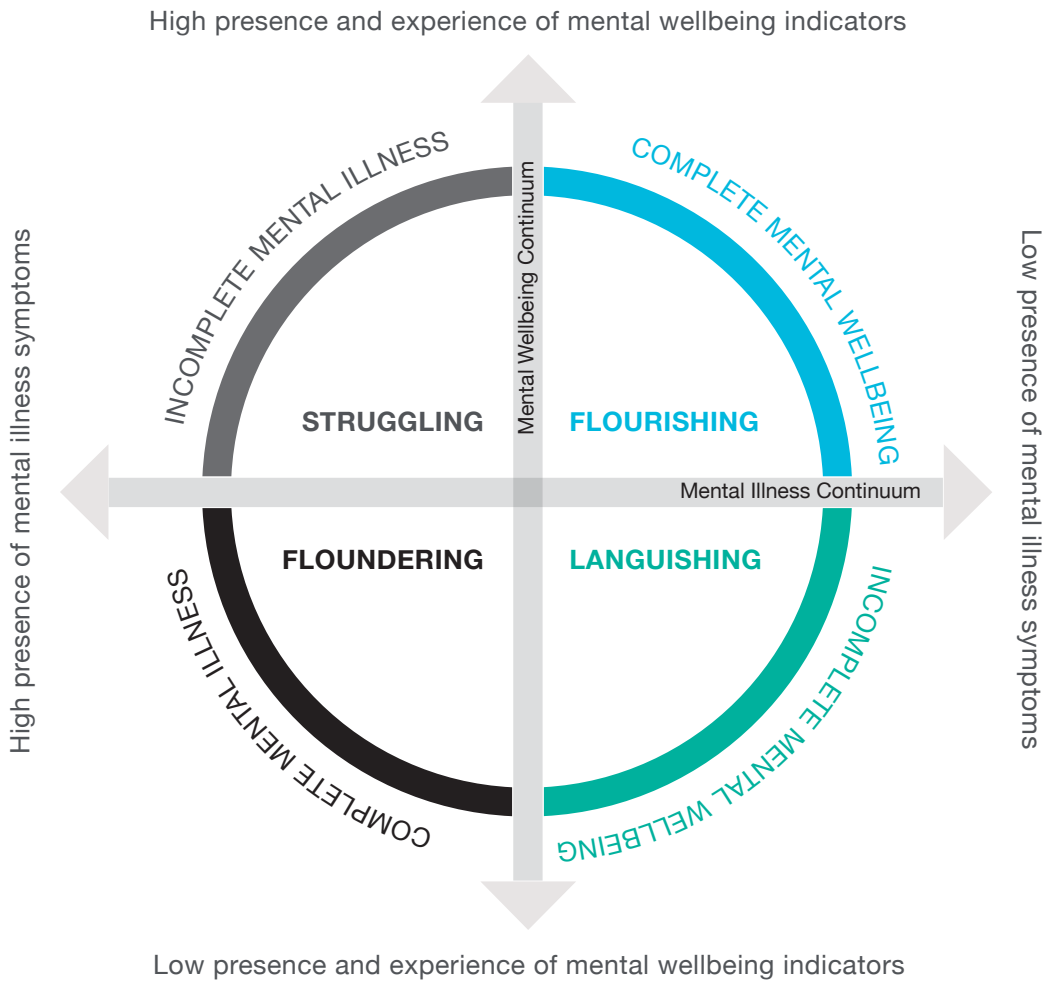

Figure 1: Dual Mental Illness – Mental Wellbeing Continuum (adapted from Keyes, C 2005)

We can all experience mental wellbeing challenges. A mental wellbeing challenge should not be considered any less distressing than a mental illness. Left unaddressed, challenges to our mental wellbeing will leave most of us languishing, severely impacting our ability to live well, work productively, and contribute positively to community life.

Mental wellbeing challenges usually result from loss, poor liveability, social disconnectedness and inequity. This impact is compounded when we have exhausted our personal resources: a loss of opportunities, loss of roles, changes in relationships, loss of purpose, experiencing racism or sexism, discrimination, loss of economic means, economic instability, inability to contribute, loss of autonomy, and personal agency.

Many of the mental wellbeing challenges that people experience, including those with an existing mental illness, are not necessarily symptoms of a mental illness, yet often are responded to as such.

A mental wealth approach which values the mental wellbeing of citizens will take seriously all levels of human distress, addressing it early with the expectation that will prevent chronic and costly states of languishing. The dual continuum of mental illness and mental wellbeing clearly articulates the valued and diverse contributions necessary within the mental health ecosystem. Reducing the burden of mental ill health and maximising the potential of people's mental wellbeing are essential service responses required to attain high levels of community mental wealth.

3.3 The potential of the Queensland Community Mental Wellbeing Sector

Creating mental wellbeing requires a different design with a different endpoint in mind. Services that lead to a connected and contributing life in the community are more likely to produce the outcomes articulated by the Productivity Commission.

The Queensland Community Mental Wellbeing Sector is an underutilised resource. There are a range of organisations, employing wellbeing specialists, adhering to a mental wellbeing philosophy, that could play a much greater role in our communities. The sector can do far more than its historical role of providing aftercare and should be repositioned as a vital adjunct to clinical treatment.

We know that just one per cent of public health funding is spent on prevention (Christensen, 2020). In the mental health context, most of this goes to early intervention in life as opposed to early intervention in illness or episode. However, early intervention in episode would ensure better outcomes for people with severe and complex issues and for those described as the "missing middle". It would also prevent the bottle necks and demand that currently plague the acute system (Table 1).

FLOUNDERING	LANGUISHING	STRUGGLING	FLOURISHING
Moderate to low states of wellbeing with moderate to high mental Illness symptoms	**Moderate to low states of wellbeing with moderate to low mental Illness symptoms**	**Moderate to high states of wellbeing with moderate to high mental Illness symptoms.**	**Moderate to high states of wellbeing with moderate to low mental Illness symptoms**
In the current system these people are the most likely to be admitted to acute mental health services and accessing community-based mental health services.	In the current system these are the people that are most likely to be accessing primary care or no services. They may be experiencing early-medium in episode distress levels. The languishing group could be considered some of the 'missing middle' that current programs are not designed for (largest % of population)	In the current system these people are likely to be managing their own mental illness symptoms well and getting on with other aspects of their life. They may be experiencing early-in episode distress levels. Likely only to access minimal treatment for mental illness.	This is a small percentage of people who are living well are resilient group but have incorporated wellbeing strategies into their daily lifestyle. They are unlikely to be accessing any formal helping services.

Table 1: Describing "Floundering" to "Flourishing" cohorts of people across the mental wellbeing continuum.

The Queensland Community Mental Wellbeing Sector must be repositioned if its capacity and skill is to be fully utilised by Queenslanders. Its new position must be as the primary entry point for those seeking wellbeing assistance. To be effective, services must be seen, promoted, and funded as a first response to community members, enabling easy self-directed access. Clinical resources would then be reserved for those who are at serious risk rather than being a catchall for distress. Such approaches would strongly align with a personal recovery-oriented direction of service delivery.

The fundamental belief must become that people should access acute treatment only when all community supports have been exhausted.

3.4 Use of technology

COVID-19 has created the need and the opportunities for the Community Mental Wellbeing Sector to quickly adapt to blended service delivery using technology. Such models have included texting, emailing, web conferencing, social media, and phone contact as well as using more highly developed web-based support platforms.

There has been mixed feedback about the use of technology in the provision of mental health care in comparison to face-to-face interventions. The value of technology in the mental health space is likely to be one of personal preference and choice. Offering blended models and evidence-informed digital interventions would allow services to reach more people.

Telehealth, E-learning opportunities, and self-guided digital self-help tools offer another line of early interventions which are easily accessible and quickly available at any time of the day. Access to these platforms does not interfere with lives and routines and deals with the initial stigma people may experience in seeking professional assistance. It normalises help seeking and allows the person to experience the assistance at their own pace and in the privacy of their own home.

Togetherall

"Togetherall is a 24 hour, 365 days a year, online service designed to help as many people as possible with anxiety, depression and other common mental health issues. The service is commissioned by more than 250 organisations across the UK, North America and New Zealand. It was established as a safe, judgement-free digital space to get support for mental health. Togetherall supports open and anonymous conversations between peers which are moderated by trained practitioners, combining the concepts of an online forum and clinical support. The service also provides a creative outlet for expression and a range of courses on mental health and lifestyle topics that can be undertaken individually or in groups. A library of resources, articles and tests are available to help users learn and track their progress. Togetherall have supported over 300,000 with their mental health and 55 per cent of members have reported feeling less isolated after using their services. Importantly, 64 per cent of members access the service out of hours" (Togetherall, 2021).

Find out more:
https://togetherall.com/en-gb/about-us

PART 4:
THE PREFERRED FUTURE

IMAGINE IT IS 2030

Everyone has access to support, designed locally that prevents mental ill-health, languishing and distress. We have the skills and resources to successfully navigate the vulnerable, uncertain, complex, and ambiguous situations we face personally and collectively. Everybody in the community can ask for help regardless of ability, health, social, cultural, or economic status and without being labelled a person with a mental illness. We all value and invest in community initiatives that foster collective wellbeing and our nation's productivity is measured not only in terms of economic growth but also by its mental wealth.

4.1 The future scope of the Community Mental Wellbeing Sector

Mental wellbeing and community wellbeing are at the forefront of this sector's preferred vision. Programs that provide mental wellbeing initiatives will support people's ability to live a contributing life. Being able to extend that approach from an individual to a community focus is crucial if the pressure points on the current system are to be alleviated.

In this future, the Community Mental Wellbeing Sector meets people where they are at, regardless of their mental ill health status. Services do not wait for people to be clinically well, instead recognising that the very provision of their support may in fact allow people to better manage their mental health.

The Community Mental Wellbeing Sector's contribution lies principally in providing responses where community members can maximise their mental wellbeing, regardless of the presence or absence of mental illness (Figure 2). Its interest is not in responding to, monitoring, or managing mental illness symptoms per se, but in supporting people to manage or overcome the impacts that prevent them from living and leading life well.

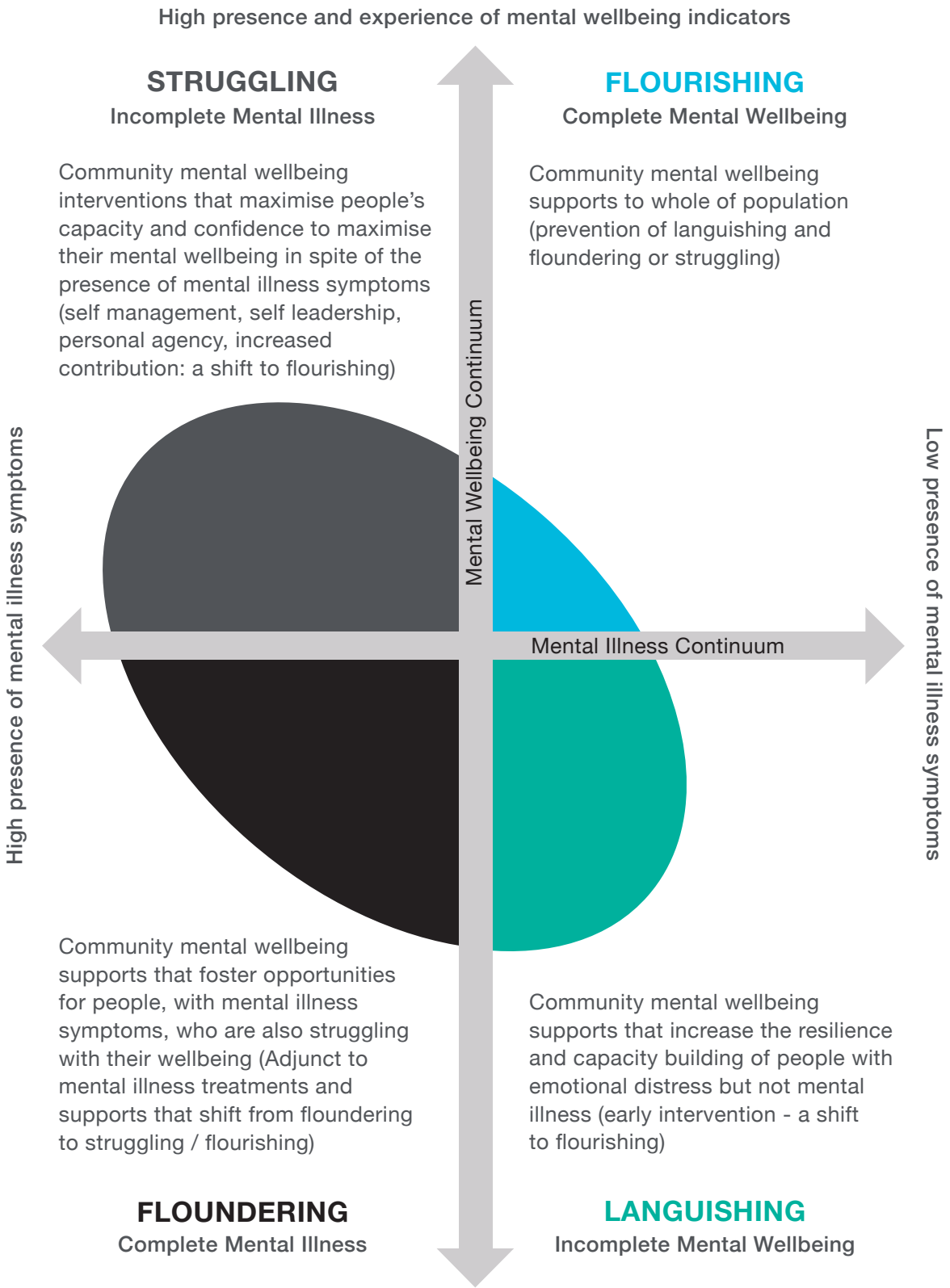

Figure 2: Proposed range of mental wellbeing service models across the mental wellbeing continuum

The future strength of the sector lies in its ability to develop models and advocate for services in the following key domains.

1. **Population Mental Wellbeing Responses**
   - Provision of resilience and adaptability initiatives across the lifespan
   - Promotion of mental wellbeing initiatives and learning and literacy across the lifespan
   - Integration of mental wellbeing initiatives within personal, social, environmental, economic and educational domains

2. **Early in Episode Mental Wellbeing Responses**
   - Focus on self-management and self-direction
   - Provision of time limited individual and group mental wellbeing coaching
   - Intentional focus on preventing states of languishing
   - Focus on enhancing mental wellbeing resilience skills and knowledge and capacity
   - Focus on maintaining social, economic and relational roles and responsibilities

3. **Mental Wellbeing Responses for Those Experiencing Acute Distress**
   - Focus on maximising personal agency, autonomy and personal control
   - Focus on assisting people to increase their capacity to navigate personal and environmental vulnerabilities
   - Provision of time limited individual and group mental wellbeing coaching
   - Provision of community alternatives to hospital that have an intentional focus on mental wellbeing outcomes
   - Provision of alternatives to the Emergency Department, providing opportunities for people to increase their capacity for managing emotional distress
   - Peer support provision that focusses on mutual capacity building and role modelling mental wellbeing

4. **Mental Wellbeing Responses for Those with Enduring Mental Illness**
   - Services co-delivered with clinical services would provide mental wellbeing supports and interventions as a speciality, giving people increased capacity to live beyond the impacts caused by a mental illness. Such programs include but are not limited to: Hospital to Home; Community Care services; Prevention and Recovery Care (PARC); Individual Psychosocial supports, Group Psychosocial supports
   - Focus on supporting people to move beyond languishing towards mental wellbeing indicators and outcomes
   - Provision of individual and group mental wellbeing coaching
   - Mental wellbeing educational programs
   - Peer support focussed on mutual capacity building and role modelling mental wellbeing
   - Services provided to NDIS clients focus on mental wellbeing recovery coaching, providing opportunities for increased capacity to live beyond the impacts caused by a mental illness

Community Wellbeing

Most community managed mental wellbeing organisations already have strong community connections, are community development minded and are leaders that can influence change.

"Community wellbeing is the combination of social, economic, environmental, cultural, and political conditions identified by individuals and their communities as essential for them to flourish and fulfil their potential."
(Wiseman, 2008)

In this preferred future, there has been a realisation that harnessing a community wellbeing approach can no longer rest on the extra commitment of individual community organisations. There is a whole of government approach to improving every community's liveability, social networks and economic and social participation. The Community Mental Wellbeing Sector is well positioned to play a pivotal role in the development, provision, and sustainability of community mental wellbeing programs.

Mental Wellbeing Outcomes

Mental wellbeing programs create intentional opportunities for people to build their capacity and strength in navigating their own domains with the personal outcomes being:

Emotional wellbeing

- People are satisfied with life overall
- People are cheerful, interested in life, in good spirits, happy, calm, peaceful, full of life

Psychological wellbeing

- Personal autonomy guided by socially accepted norms and values
- Environmental mastery, ability to adapt environments to meet personal needs
- Seek challenges that lead to personal growth and development
- Seek and maintain positive relations with others
- Articulated life purpose, direction and meaning
- Is self-accepting

Social wellbeing

- Social acceptance of others, acknowledging and tolerating differences
- Social actualization acknowledging that people, groups and communities change and grow positively
- Socially contributes in ways that are perceived as useful by themselves and others
- Social coherence interested in society life
- Socially integrated, feeling a sense of belonging to a community and comfort from a community

4.2 The Characteristics of Community Mental Wellbeing Service Design

The Characteristics of a Community Mental Wellbeing Service:

- Population focus
- Partner with local community resources
- Locally responsive to the needs of the community
- Specialise in linking people with naturally occurring community resources
- Offer a direct entry point without medical intervention
- Have a strong customer service philosophy
- Understand and are relevant to people's needs
- Provide programs that foster mental wellbeing
- Provide early in distress support options
- Provide a mental wellbeing coaching approach
- Person-led not person-centred
- Use technology where appropriate

Assessment of the quality and efficacy of services in the Community Mental Wellbeing Sector should predominantly be determined by the people who access them; how they are experienced and whether they have been able to assist people to better meet their needs and overcome the mental wellbeing challenges they face. System stakeholders have articulated that new community centric models must embrace (i) a whole of population approach, (ii) demonstrate a strong customer service philosophy, (iii) be person led, with a (iv) focus on personal recovery outcomes.

A whole of population approach for the sector requires a commitment to several key characteristics in its funding, design and delivery approaches. From our consultations the following program characteristics are considered crucial to such an approach.

Considered a Whole of Governments' Responsibility

Mental wellbeing and community wellbeing is much more than a health or an illness issue. Supporting wellbeing is the responsibility of the entire community and requires commitment from all government departments – not just health. Wellbeing should also be central to child safety, education, employment, social services, housing, transport, emergency services and the NDIS.

Respond Locally, Based on the Wellbeing Needs of the Community

To develop relevant local mental wellbeing services there is a crucial need to shift away from prescribed national or state-wide responses towards locally designed solutions with greater agility to respond to the specific wellbeing needs of that community. The level of liveability, range of social networks, and a community's equitable culture is crucial to sustain mental wellbeing and build its mental wealth. Funding must also be adaptable and responsive to community needs, resisting a one size fits all approach for every community.

Specialise in Programs that Link People with Natural Connections and Community Resources

Natural connections and resources include a person's family, friends, and community support networks including special interests, social and sporting groups. The role of the Community Mental Wellbeing Sector is not to replace natural resources but to intentionally provide opportunities for people to re-engage with their relationships and community.

Offer a Direct Entry Point

The Community Mental Wellbeing Sector must be both a first option and open access resource for communities if it is to address local needs as well as reduce the demand placed on clinical services. Community mental wellbeing services providing direct access can escalate to clinical services if required.

Uphold a Strong Customer Service Philosophy

The Community Mental Wellbeing Sector prides itself on adopting a strong customer service philosophy. This is not always easy, nor does it always come naturally. It requires constant support and resources to ensure the culture of all service delivery aligns with a strong customer service ethos. Customer centric organisations are hospitable, relational, empathic, attentive, interested, responsive, relevant, knowledgeable, reliable and have frictionless touchpoints. They value and seek constant feedback.

Cleveland Clinic

Cleveland Clinic believes that patient care is about "building a connection that encompasses mind, body and soul" (see text in YouTube clip below). Its philosophy embodies an empathic, person-centred approach, led by the clinic motto "Every Life Deserves World Class Care". It is a non-profit academic medical centre in Cleveland, Ohio, and one of the top hospitals in the US. It runs events for the hospital's community and "friends"; one example of this is an online art class, titled "Conversations to Remember", which the clinic says would benefit those with cognitive decline but is also a fun "engaging social exchange".

This video effectively shows Cleveland Clinic's approach to the people it supports:

https://youtu.be/cDDWvj_q-o8

https://my.clevelandclinic.org/

For more:
https://www.patient-experience.org/Home

Responsive and Relevant to People's Unique Needs

Quality mental wellbeing services will work to fit their resources to people's needs and not vice versa. Remaining attentive to people's needs and then adapting in response, will help ensure that services are not overdelivered, underdelivered or misdelivered. Contemporary community mental health organisations appreciate that the challenge in providing a helpful service, lies with the model and not the participant.

Stretch2Engage

Stretch2Engage is an organisational engagement framework developed for the Queensland Mental Health Commission and tested by several Queensland mental health and alcohol and other drug organisations. Stretch2Engage is underpinned by a philosophy which places the responsibility for engagement with the service and not the individual. It shifts the culture of an organisation to one where the primary questions are.

How can we engage better with you? How can we understand your needs to adapt our service to meet your needs?

Services who trialled this framework and methodology strengthened their engagement with their participants by Stretching2Be: Curious, Clear, Creative, Collective, Comprehensive, Champion and Committed. These services aspired to uphold a person first service culture and described greater levels of engagement in their service because of implementing the framework.

www.qamh.org.au/wp-content/uploads/Fin_20180903_Stretch2Engage-Framework.pdf

STRETCH 2 ENGAGE

Provide Specialised Programs that Foster Mental Wellbeing

Mental wellbeing programs should be available across the lifespan to give people increased emotional intelligence to manage the volatility, uncertainty, chaos, and ambiguity that may come their way. Services would foster intentional and meaningful opportunities for people to retain or regain full community membership outside the confines of accessing a helping service.

Mental wellbeing programs focus on skills development, problem solving capacity, self-efficacy, and social coherence. There is a strong focus on mental wellbeing literacy beyond the limitations of a mental illness literacy framework. Mental wellbeing programs believe it is in the doing that mental wellbeing is experienced. There is a very early focus on regaining or retaining employment, education, parenting, valued social roles, relationships and responsibilities. They work with complementary health and community service providers, upholding a person-led philosophy.

Provide Early in Distress Support Options

The Community Mental Wellbeing Sector's niche contribution and specialisation promotes flourishing states of wellbeing and works to prevent languishing, even when working with people experiencing higher levels of mental distress or mental illness acuity. The sector must also be willing to provide mental wellbeing services, regardless of the level of distress, in both social and unsociable hours if it is to be truly responsive to community need and be considered a viable alternative and adjunct to clinical services.

Provide a Mental Wellbeing Coaching Approach

Mental wellbeing supports, interventions and programs are well suited to a coaching philosophy. A coach is a collaborative partner who works with the learner to help them achieve goals, solve problems, learn and develop (Caplan, 2003). Coaching differs greatly from traditional support, in that coaches resist taking 'responsibility for' but remain responsible 'to' the participant. Coaching titrates its approach in relation to people's existing capacity, desired capacity and willingness to stretch to new capacity at any given time.

Person-Led not Just Person-Centred

Person led services believe that people are the leaders of their life and service providers are simply team members whose role it is to support the leader in reaching their wellbeing vision. Services are accountable to the person for their service delivery. They intentionally provide supports that give people a greater sense of personal agency and self-leadership. A person-led mental wellbeing philosophy disrupts the notion that people need to be cared for, case-managed, or service- coordinated. If mental wellbeing is to be fully experienced, people must not be hindered in adopting their active leadership role. They must be supported in their own work to seek and negotiate the mental wellbeing resources they require to live and lead their life well. Many person led services use coaching techniques to work with individuals to achieve their potential.

Use of Technology

Telehealth, E-learning, and self-guided digital self-help tools offer a line of early intervention which is easily accessible and available at any time of the day. Access to these platforms does not interfere with lives and routines and avoids the initial stigma people may experience seeking professional assistance. It normalises help seeking and allows the person to experience the input at their own pace and in the privacy of their home if they choose.

Stigma Cutz

Stigma Cutz is a not-for-profit charity barber shop in Brisbane which aims to tackle the stigma surrounding mental health and suicide among men. The shop employs barbers who are certified in mental health first aid and features a pool table, a TV, gaming consoles and refreshments for the clients to enjoy in a safe and relaxing environment. It is an initiative from A Chance for Change, a charity aimed at preventing depression in men with 100% of the money from Stigma Cutz going back into the charity. The founders of Stigma Cutz have cited the environment of open conversation typically found at barber shops as the foundation for the project, combining this open and friendly atmosphere with the therapeutic expertise of its workers. Clients are often referred to mental health professionals if they express interest in further assistance, which is facilitated through the barber shop's network of mental health professionals. Barber shops with similar goals and approaches can also be found in other parts of the world, such as the Lions Barber Collective in the UK which aims to raise awareness of suicide prevention.

Find out more:
www.stigmacutz.org.au

4.3 Mental wellbeing program characteristics to be resisted

Service models can inadvertently foster dependence rather than competency, knowledge, confidence, and personal control. To mitigate this risk, high quality mental wellbeing programs resist the following:

- Benevolent supports and interventions that solely alleviate distress and do not lead to sustainable mental wellbeing outcomes
- Programs that create dependence
- Service delivery practice that reinforces the permanency of distress
- Services that overservice, underservice, or misservice people's needs
- Adopting 'case' management as a model of care
- Adopting the expert role in peoples' lives, determining what is thought to be best for the person or in their best interest
- Medicalising and pathologising the nature of people's distress in either use of language or as a meaning making construct
- Placing low expectations on an individual's recovery, based on their acuity
- Working in service silos
- Working in competition with other providers
- Duplicating naturally occurring supports and resources

PART 5:
QAMH LEADING INTO THE FUTURE

THE WORK AHEAD

QAMH has developed some strategies that will flow from this vision and will form the work of QAMH throughout the coming years.

QAMH has developed this preferred future for the Community Mental Wellbeing Sector. It has been formulated in consultation with the sector and key stakeholders, by using strategic foresight thinking to project a vision for the next 10 years.

This report has highlighted that the Queensland Community Mental Wellbeing Sector is only one component of a very large and complex ecosystem. Our view is that a range of responses will always be required to ensure the system can meet the varied needs and preferences of the population. We are conscious that integration within the system and across systems is crucial, and that the Community Mental Wellbeing Sector needs to embrace its unique place in the context of the broader system to be most effective.

As an organisation QAMH is committed to this vision and we invite our members and stakeholders to explore and develop the framework presented in this document. Our hope is that through our collective effort we can work together with all parts of the mental health ecosystem to actively support community wellbeing.

We have developed some strategies that will flow from this vision and will form the work of QAMH throughout the coming years.

5.1 Lead and influence the unique value of the sector

While we have articulated a future state for the Community Mental Wellbeing Sector, we do this knowing that it will require a shift in philosophy within the whole mental health ecosystem and at all levels of government. As with all major change, we know there will be resistance and differing views. We are clear that the cultural barriers need to be overome before resources are invested and reallocated.

It is our intention to work with our sector to strengthen this position and articulate more fully what this future looks like. We are committed to engaging in considered discussions with other elements of the system to explore and develop the framework and practice principles. We will hold a series of workshops in 2021-22 to explore ideas and generate interest in this change.

5.2 Modelling service design

QAMH will work with our sector, people with lived experience and other key stakeholders in the modelling and design of local mental wellbeing services. It is our intention to use the advice gained through these workshops to develop mental wellbeing service and program models for the purposes of funding and implementation.

5.3 Strengthening workforce wellbeing capability

QAMH is aware that we have a skilled and adaptable workforce but that the mental wellbeing service and program models developed could require new skillsets. In addition to the current work QAMH is doing on mapping and describing the current workforce and career pathways, we will identify the new skills required and work with training organisations and service providers to enable this skill development.

This work will include identifying key values, philosophies and attitudes required, as well as designing practice principles that the sector workforce can identify with.

5.4 Build a collection of mental wellbeing resources

QAMH will develop a range of resources for use by the sector in designing and developing their services. We will look to partner with universities to plan research, evaluate models and develop learning platforms to develop the wellbeing expertise of the sector.

METHODOLOGY

This report was informed by a process of strategic foresight research and exploration. The research began with horizon scanning (otherwise known as environmental scanning), an intentional and directed mode of looking, documenting, and analysing our environments for change (Voros & Choo, 2003). Horizon scanning is a way of identifying weak signals and trends that may have significant impacts (Molitor, 2010; Hiltunen 2008). The horizon scanning was supported by the Futures Action Model framework (Ramos 2013), as well as digital mapping technology for logging data (Sharp & Ramos, 2018). The horizon scanning frame included:

Emerging Futures

- Examples of emerging mental health needs (stories from the front line of community mental health)
- The social, economic and mental health implications and projections from COVID-19
- How the pandemic changes community mental health needs
- Long term trends in mental health
- Emerging issues or trends that have potential significance to community mental health
- New visions for community mental health from around the world

Pioneering Responses from Around the World:

- Examples of pioneering projects in community mental health
- Examples of innovative responses in community mental health to COVID-19
- Examples of government community mental health collaborations on COVID-19 responses
- Examples from self care / community mutual aid on mental health
- The impact of COVID-19 on other sectors (hospitals / commonwealth / NDIS / etc)

The research involved a number of workshops and engagements using various methods. Some of these were internal to QAMH staff, while others included community members invited for their expertise (see chart below). The Futures Triangle (Inayatullah, 2008) was used in the early part of the project, to map the overall scope of the problem area, identifying critical factors. Vision Cycles, informed by the work of Fred Polak (1973), is a timeline method that asks how implicit visions influence the actions of people. The technique helped the team understand the history of the sector, today's dominant vision of the future, and the emerging visions of the sector. Three Horizons of Change (3H) is a foresight model developed by Curry and Hodgson (2008). 3H was used to analyse why the current mental health system is declining in its ability to respond to societal needs. The method supported the development of a preferred vision for the Community Mental Wellbeing Sector. It was also used to understand the transition dynamics from the current mental health system to a system with greater strategic fit to the needs of the Queensland community. Finally, it helped to articulate what the future may look like without reform. Causal Layered Analysis (CLA) (Inayatullah, 1998) was used to understand the deeply held cultural patterns that exist in the mental health community and the deep assumptions that underpin the creation of the future, and to enable creative reframing of cultural patterns. Participatory futures is a way to engage the public in thinking about the future (Ramos, et al., 2019). The QAMH team developed a participatory engagement with QAMH members which asked: "What does community mental health look like in five years time if there is no reform?". The engagement provided a future scenario for members to engage with, including fictional characters and roles within the mental health sector.

Summary of engagements:

METHOD	INVOLVEMENT
Futures Action Model Horizon Scanning	Core QAMH Team
Futures Triangle	Core QAMH Team , 3-4 guests from MH sector
Vision Cycles	Core QAMH Team, 7 guests from MH sector
3 Horizons	Core QAMH Team, 10 guests from MH sector
Causal Layered Analysis	Core QAMH Team
Participatory engagement with QAMH membership	2 members of QAMH Team 25 guests - members of QAMH

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Telephone: 07 3394 8480 **Email:** admin@qamh.org.au
Address: 433 Logan Road, Stones Corner QLD 4120
Visit us at **www.qamh.org.au** **ABN:** 23 216 177 453