Pathways to mental wellbeing

Key success imperatives

A systematic analysis of the non-government community mental health sector in Queensland

Queensland Government

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your feedback on this plan.

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Executive summary

The Queensland Mental Health Commission (the Commission) in partnership with the Queensland Alliance for Mental Health (QAMH), have undertaken a systematic analysis of the non-government community mental health sector in Queensland to gain a comprehensive understanding of its strengths, weaknesses, opportunities and challenges.

The purpose of this analysis is to inform strategic action in the non-government community mental health sector in Queensland over the next five years and to achieve a fundamental shift from managing illness to actively supporting wellbeing. This shift is also outlined as a priority in the QAMH's *Wellbeing First* report. It also aligns with the Commission's broader Queensland government's vision, articulated in *Shifting minds: The Queensland Mental Health, Alcohol and Other Drugs, and Suicide Prevention Strategic Plan 2023–2028 (Shifting minds)*. The primary aim is to reorientate the mental health system towards community-based services and supports.

The systematic analysis explores and critically evaluates the current state of the sector and offers a roadmap for moving beyond existing models of care. This is an opportunity to maximise the potential of the non-government community mental health sector and embrace its unique offering within the broader mental health system.

Griffith University and QIMR Berghofer Medical Research Institute were engaged by the Commission and QAMH to undertake background research for this report. The research team undertook a literature review, and coordinated a number of focus groups, interviews and surveys to independently collate views from people with personal lived experience of mental illness, including carers, family, kin and other supporters; non-government organisation (NGO) staff; and vulnerable population groups. This work informed this report, adds weight to the analysis and builds upon previous bodies of research into the sector.

There is much evidence to suggest that the non-government community mental health sector provides invaluable, highly effective, and life-changing supports for people in distress. However, there is also a sense that the sector is prevented from reaching its full potential by significant challenges such as insecure and unsustainable funding models, geographic maldistribution of services, ongoing stigma and discrimination, and a system that continues to prioritise clinical approaches over non-clinical psychosocial supports. System-wide challenges such as workforce shortages, difficulties accessing a complex system built upon eligibility criteria, and lack of culturally appropriate services are well-documented. There is also a collective view that despite positive signs that lived experience is becoming embedded within the sector, there is still a lot of work to be done in terms of truly equal partnerships and co-production of service design and delivery.

Looking to the future, there is strong alignment between people with a personal lived experience of mental illness, including carers, family, kin and other supporters, and NGO staff on the strengths of the sector which include commonality of purpose, close connection with community, and the positioning of the sector at an important intersection between broader health and community systems.

A clear message running through this systematic analysis is a battle-weariness that comes from participating in a long line of reviews, inquiries, reports and analyses which fail to implement real change. There is a widely held view that the recommendations for reform presented here must be accompanied by tangible action at a grassroots level. The five-year Roadmap presented at the end of this report is the coalescence of the many voices heard throughout this systematic analysis. It identifies the success imperatives as sector visibility and identity, lived experience, data and evaluation, integration and coordination, funding reform, workforce development and innovative community-based responses. It provides the blueprint to bring about deep transformational change, pivoting to a new way of supporting people in distress and actualising the *Wellbeing First* vision.

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We would like to acknowledge the valuable contributions and efforts to this project from the following stakeholders:

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A note on language

We acknowledge the importance of language and note that there is no current consensus on the language used in relation to lived/living experience. For this report, the term 'lived' is used to refer to anyone with either a current or ongoing (living) or previous (lived) personal experience of mental ill-health and experience of engaging with services, supports and the broader health and wellbeing sector. This also applies to a family member, carer, kin, or chosen support person, who have regularly provided unpaid care or support for a person living with a mental ill-health, and/or alcohol or other drugs (AOD) use, and/or suicidality.

Within this report, the term 'consumer' and 'carer' may also be used where this was the language within data collection methods, such as the survey tools.

Background

Policy context and background

The last five decades have witnessed a reorientation towards community-based supports for people with mental distress. This began with deinstitutionalisation in the 1970s and 1980s where stand-alone psychiatric hospitals were replaced by mental health beds in general hospitals and community-based services — a process that had far reaching implications for the mental health system. The result was not only a transition of clinical interventions into community settings, but also the emergence of a wide range of non-clinical 'psychosocial' supports delivered by NGOs "with the recognition they could deliver some services more efficiently or more effectively than the government or the private sector".[1] Central to this evolution in Australia's mental health system was the emergence in the 1970s of the lived experience movement (often referred to as the consumer and carer movement), and recovery-oriented practice, with deeply embedded views about human rights and community inclusion of people affected by mental ill-health.

In 1992, after a decade of adverse publicity and a series of public inquiries into mental health services, all Australian governments adopted a National Mental Health Policy.[2] The Policy, implemented through a series of five-year National Mental Health Plans became known as the National Mental Health Strategy. Every National Mental Health Plan, up to and including the current fifth iteration, has expressed a commitment to:

- strengthening community-based supports and services
- shift the focus beyond severe and complex mental illness to include the whole spectrum of experiences, including prevention and early intervention
- prioritise workforce planning and development, and
- better integrate services through cross-sector collaboration.

Under these National Mental Health Plans, government investment in community-based services including the NGO sector burgeoned over the next few decades, hitting its peak in 2016–2017 with $97 million spent in Queensland on the non-government community mental health sector (or 8 per cent of total mental health expenditure).[3] During this time, initiatives such as Partners in Recovery (PIR) and Personal Helpers and Mentors (PHaMs) were funded by the Australian Government for people with severe and complex mental health challenges. These programs took a strengths-based recovery approach to support people to better manage their daily activities and reconnect with their community. They had a particular focus on strengthening partnerships and working more collaboratively across services and sectors.

The introduction of the National Disability Insurance Scheme (NDIS) in 2013 irrevocably altered the mental health landscape. At the time of writing, the NDIS supports 60,864 Australians[4] who have met strict eligibility criteria to prove they are permanently impaired by their psychosocial disability. Current projections state that there will be 88,180 participants with psychosocial disability by 2030.[5] Despite representing the most significant social and disability reform in Australia since Medicare, the scheme disrupted traditional models of care within the mental health system and caused a major realignment of service provision, large-scale workforce shifts, and a new reliance on fee-for-service funding. It has faced criticism for its complexity, inaccessibility and appropriateness for people with mental illness. The focus on permanency and functional impairment that underpins the NDIS is diametrically opposed to a wellness and recovery framework. Most concerningly, its implementation has created a gap in service provision for people who do not meet eligibility criteria, with both Australian and state governments reallocating funding from psychosocial programs (such as PHaMs and PIR) in the process of transitioning to the NDIS. Estimates from the National Mental Health Services Planning Framework (NMHSPF) suggest that 151,000 people with severe and persistent mental illness who would benefit from psychosocial supports are missing out. At the time of writing, the NDIS was undergoing a wide-ranging review "to look at the design, operations and sustainability of the NDIS".[6]

More recently, the Australian Productivity Commission's 2020 *Mental Health Inquiry Report* was a watershed moment in documenting Australia's mental health crisis. It confirmed what previous reports had alluded to — that the nation is facing a mental health emergency, the system is not fit for purpose and radical change is needed. Among its 24 recommendations, it recommended that governments improve the availability of psychosocial supports which "help people experiencing or recovering from mental illness to achieve higher levels of wellbeing and engage with their communities".[7] This was welcomed by the non-government community mental health sector, however tangible actions have not been forthcoming.

The Australian Government's response to the *Mental Health Inquiry Report* was the *National Mental Health and Suicide Prevention Agreement* (the National Agreement) signed by the Commonwealth and eight states and territories in March 2022, which sets out the shared intentions and responsibilities of each level of government. Bilateral agreements between the Commonwealth and respective states provide further detail, including financial contributions. Despite much anticipation, this National Agreement left many questions unanswered. It did, however, recognise that psychosocial supports are an important part of a well-equipped mental health system and that governments should work together to develop and agree on future psychosocial support arrangements. The National Agreement commits to an estimation of demand (compared to current availability) for psychosocial supports outside of the NDIS through a comprehensive state-based mapping of all current psychosocial support services outside of the NDIS, led by the States and Territories and supported by the Commonwealth. This work was in progress at the time of writing.

In Queensland, a *Parliamentary Inquiry into the Opportunities to Improve Mental Health Outcomes for Queenslanders* (the Queensland Mental Health Inquiry) was announced by the Health Minister in December 2021. This six-month inquiry received 164 submissions and held a number of public hearings. Contained in its 57 recommendations are many with direct relevance to the non-government community mental health sector, chiefly that "the Queensland Government reviews existing community-based mental health services and programs and finds opportunities to expand services".[8] It also made recommendations around sustainable funding mechanisms (implemented by the Queensland Government in the form of a business levy from 1 January 2023), expanding alternatives to emergency departments, increasing and regulating the lived experience (peer) workforce, and expanding services for specific populations such as Culturally and Linguistically Diverse (CALD), First Nations and LGBTIQA+. *Better Care Together: A plan for Queensland's state-funded mental health, alcohol and other drug services to 2027 (Better Care Together)*, *Shifting minds, Achieving balance: The Queensland Alcohol and Other Drugs Plan 2022–2027 (Achieving balance)* and *Every life: The Queensland Suicide Prevention Plan 2019–2029 (Every life)* encompass the Queensland Government's response to the Queensland Mental Health Inquiry. They are ambitious strategies for mental health reform, supported by an unprecedented investment of $1.645 billion over five years. Whilst this investment has some dedicated investment for the non-government community mental health sector, additional resourcing to position the sector for growth to meet current need, and sustainability is required.

There are very few areas of public policy that have been subjected to as much scrutiny as mental health. Since the landmark *Report of the National Inquiry into the Human Rights of People with Mental Illness* (the 'Burdekin Report') in 1993, there have been more than 30 significant reports, reviews, inquiries and royal commissions that have recommended major reform to the mental health system.[9] These critiques have been highly similar, echoing calls to redress the imbalance between hospital and community care, create more integrated and place-based models of care, invest in prevention and early intervention strategies, build workforce capability, and elevate the role of people with lived experience in shaping reform.

The recent major policy developments described here are promising and it is conceivable that we are on the cusp of transformational change. However, in the midst of these tectonic shifts, it is important that the non-government community mental health sector is not overlooked. This systematic analysis endeavours to gain a comprehensive understanding of the strengths, weaknesses, opportunities and challenges facing the sector and how it can harness its unique potential within the broader mental health system.

Mental illness, mental health and mental wellbeing

While the words mental illness, mental health and mental wellbeing are often used interchangeably, there are important differences. ***Mental illness*** is the presence of a clinically diagnosable disorder that significantly interferes with a person's cognitive, emotional or social abilities.[10] The term is rooted in the biomedical model and covers a range of medical conditions including anxiety disorders, affective disorders, psychotic disorders and substance use disorders. ***Mental health***, by contrast, is defined by the World Health Organisation as a state in which "the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community".[11]

There has been a recent trend towards using the language of ***mental wellbeing***, which acknowledges a complex interplay of emotional, psychological and social factors. It takes a more holistic approach, encompassing the environmental factors that affect us and how we function in society. It includes factors such as satisfaction with life, a sense of purpose and belonging, social participation, community connectedness, strong relationships and self-acceptance. QAMH's *Wellbeing First* report is a call to fundamentally shift the focus from managing illness to actively supporting wellbeing.

Australian statistics

National datasets continue to capture incidence of mental illness as opposed to mental wellbeing. While there have been some smaller studies that include wellbeing measures (Mental Health Australia's *Report to the Nation* and Smiling Mind's *Australian Mental Wellbeing Index*), most larger population studies rely on clinical diagnostic criteria and/or biomedical understandings of mental illness.

According to the *National Study of Mental Health and Wellbeing*, 21.4 per cent of Australians will experience a mental illness in any given year and 43.7 per cent will experience a mental illness in their lifetime.[12]

It is well documented that specific populations demonstrate higher levels of mental illness than the broader population. Results from the *National Study of Mental Health and Wellbeing* show that:

- Females are more likely to have a 12-month mental illness compared to males (24.6 per cent compared to 18 per cent). They are also more likely to experience high or very high levels of psychological distress than males (18.6 per cent compared to 12 per cent).

- Younger people (aged 16–24 years) are more likely to have a 12-month mental illness compared to the general population (39.6 per cent compared to 21.4 per cent) and high or very high psychological distress (20 per cent compared to 15.4 per cent).

Population data for Aboriginal and Torres Strait Islander peoples demonstrates a significantly higher rate of high or very high psychological distress (31 per cent compared to 13 per cent for non-Indigenous Australians).[13] The suicide rate in Aboriginal and Torres Strait Islander peoples is twice that of the non-Indigenous population, and suicide occurs at much younger ages.[14]

In addition, populations living in disadvantaged areas have higher levels of psychological distress, as illustrated in the Australian Productivity Commission's *Report on Government Services 2022*. Adults living in the most disadvantaged areas are 2.5 times more likely to have high or very high psychological distress compared to adults living in the least disadvantaged areas.[15]

The effect of the COVID-19 pandemic on the incidence of mental illness in Australia is unclear.[16] While there has been much commentary on the mental health implications of the virus itself and subsequent social distancing measures to contain its spread, this has not yet been supported by available longitudinal data. The Australian Institute of Health and Welfare (AIHW) reported a rise in the use of mental health services throughout the pandemic in 2020 and 2021.[17] Butterworth et al. found a small but statistically significant effect of lockdown on mental health, with greater decline for residents of Victoria in 2020 than for those in the rest of Australia.[18] Biddle et al. found a substantial decrease in life satisfaction and increase in psychological distress during the first few months of the pandemic, which has not returned to pre-COVID-19 levels. This was found to be most marked in the 18–24 age group, those with lower educational attainment, and lower income. Larger population studies are needed to explore these phenomena more comprehensively.[19]

Australian statistics

Females and younger people
are more likely to have a
12-month mental illness
and
experience **high or very high psychological distress**
compared to the general population

Queensland statistics

Queensland has the
2nd highest suicide rate
in Australia
and
higher rates of mental health presentations
to emergency departments

Queenslanders consistently experience
higher incidence of mental health conditions

Suicide is the leading cause of death
for **First Nations** Queenslanders aged 15–35

Queensland statistics

While these national statistics are broadly consistent with Queensland's incidence of mental illness, there are some discouraging signs that Queensland may be diverging from national trends. The *2021 Census* highlighted a higher incidence of long-term mental health conditions in Queensland (9.6 per cent) as opposed to nationally (8.8 per cent).[20] In the *National Health Survey*, 22.7 per cent of Queenslanders self-reported a mental health condition which was the highest of any state or territory, and above the national rate of 20.1 per cent, with a long-term trend that suggests continued divergence (see Figure 1).[21] Research to further clarify this trend is needed.

Queenslanders consistently experience a higher incidence of mental health conditions.

Queensland has the second highest suicide rate in Australia, behind the Northern Territory, with rates of male Indigenous suicide significantly higher (43.5 suicides per 100,000 in Queensland compared to 39.8 per 100,000 nationally). Suicide is the number one cause of death for Aboriginal and Torres Strait Islander Queenslanders aged 15–35 years.[22]

While it is an indirect marker of mental illness, Queensland has rates of mental health presentations to emergency departments above the national average. Since 2016–17, there has been a 2.2 per cent average annual increase, which is also above the national rate of 1.5 per cent.[23] Queensland's self-harm hospitalisations are 1.6 times the national rates.[24]

Compared to national data, Queensland also performs poorly on a number of social determinants of mental health, such as median weekly household income[25] and incarceration rates.[26] Homelessness has been a particular issue in Queensland, rising by 22 per cent since 2017, compared to only 8 per cent across Australia. This has been most marked in regional Queensland, where demand for specialist homelessness services increased by 29 per cent in the past five years.[27]

Certain regions in Queensland experience particular disadvantage. SGS Economics and Planning have developed a national index which looks at wellbeing indicators such as economy, income and wealth, employment, knowledge and skills, housing, health, equality and the environment. According to this wellbeing index, five Queensland regions (Burnett, Caboolture, Hervey Bay, the Charters Towers-Ayr-Ingham region and Queensland's Far North) were ranked in the bottom 10 within Australia.[28]

Queensland's unique socio-economic challenges include a population growing faster than the national rate, with particular increases in the older age-groups and people from CALD backgrounds. It also has the most decentralised population in Australia.[29] The Queensland Government Statistician estimates another 957,887 Queenslanders in the next ten years (2023–2033).[30] Extrapolating from current data, this would mean approximately an additional 217,440 people with mental illness in Queensland needing access to services. With a mental health system already experiencing high demand, it is critical that we now transition to a system with the capacity and agility to face these future pressures.

Figure 1: *Trends in self-reported mental and behavioural problems (trends)*
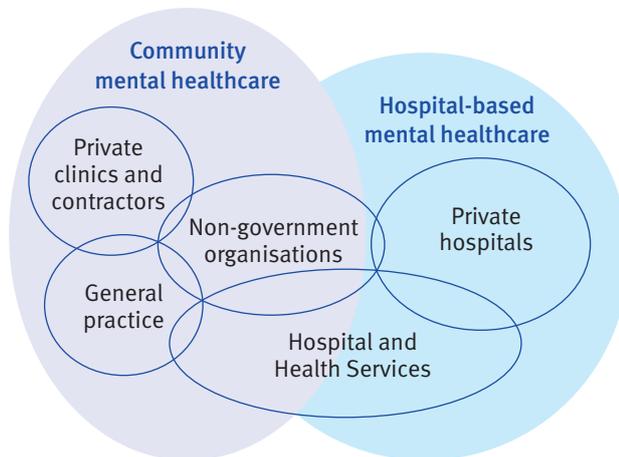

Source: Australian Bureau of Statistics, 2018. Note: There is a time series break due to a methodological change in 2014–15.

Australia's mental health system

Responding to this escalating incidence of mental distress in Australia, and Queensland in particular, requires a mental health system that is fit for purpose. Understanding the existing mental health services landscape (and the NGO sector's place within that landscape) is crucial if we are to comprehensively review and rethink mental health services and supports.

In Australia, the mental health system reflects the Balanced Care Model, involving a combination of primary, secondary and tertiary mental health services across community and hospital settings (Figure 2).

Figure 2: *Australian mental health service overview*

Funding

These mental health services are financed by a patchwork of funding arrangements, which reflects the complex nature of Commonwealth-State relations. The Commonwealth government distributes funding for mental health services through Primary Health Networks (PHNs), Medicare, the National Disability Insurance Agency (NDIA), the Department of Veterans' Affairs, and other funding arrangements. Federal funding for mental healthcare can be accessed by individuals, NGOs, general practice, private clinics, and Hospital and Health Services (HHSs).

In Queensland, state government funding for specialist mental health support services is distributed by Queensland Health through service agreements with HHSs and NGOs. While HHSs predominantly provide hospital- and community-based clinical services, NGOs provide community-based services that can be clinical or non-clinical depending on funding and contracted service delivery. Traditionally, the division of Commonwealth and State responsibility has seen the Commonwealth fund treatment of high prevalence mental health conditions such as anxiety and depression through primary healthcare, and the States fund treatment of more severe mental illness through public mental health services.

Expenditure on mental health services and supports has increased at both a national and state level. In 2020–21, $11.6 billion, or $451 per person, was spent on mental health-related services in Australia, representing a real increase from $418 per person in 2016–17. This equates to a 2 per cent annual average increase in the real per capita spending on mental health-related services.[31]

Joint regional planning and commissioning

Decisions about what services to fund and where they should be located are ideally made at a regional level. Using the NMHSPF, a tool that uses epidemiological data to estimate the amount and type of mental health supports required for a particular population, the PHNs, HHSs and other key stakeholders can compare what supports are currently available with what is required — a 'gap analysis'. This allows limited resources to be best allocated to meet demand, avoids duplication and achieves better outcomes for local communities. In practice, however, these arrangements have not always been collaborative and it is acknowledged that work is needed to strengthen local planning and commissioning partnerships. The National Mental Health and Suicide Prevention Agreement specifically stated that "the Parties agree to work together to strengthen regional planning and commissioning of mental health and suicide prevention and psychosocial services to provide person-centred care and place-based care".[32]

The non-government community mental health sector

Definition

The non-government community mental health sector occupies a unique place within the broader mental health system. It incorporates a wide range of non-profit, community-based psychosocial supports provided throughout the mental health continuum — from early intervention to severe and complex mental illness. Services offer practical supports to help people connect with their communities, build on their strengths and increase their capacity to live a full and meaningful life. They use recovery-oriented, trauma-informed knowledge to work with people to re-establish their lives beyond illness and take a whole of life approach supporting people to navigate and respond to their broader needs including housing, employment, legal issues, family support and alcohol and drug use challenges.

Defining the exact composition, practice, scope and boundaries of the sector has been a constant challenge, evidenced by the number of definitions populating the literature. This failure to clearly define the sector at a state or national level has been problematic, undermined advocacy efforts and resulted in the sector being undervalued and under-represented in strategic policies and plans. Precisely capturing the nature and scope of work performed by the sector in the form of a core competency framework or practice standards would help to promote understanding of the sector more broadly.

This lack of coherency extends to the language used to describe the workforce. People are employed within the sector under a variety of job titles such as mental health recovery support worker, community mental health worker, mental health lived experience peer worker, psychosocial recovery coach, wellbeing coach or lifestyle facilitator. This illustrates the lack of commonality in language applied to roles which — with some nuances — are reasonably consistent in terms of skills, knowledge and values required.

Profile of service offerings

The diversity of service offerings of each NGO is largely determined by the funding contracts they can competitively secure and the mission and values governed by their Board. NGOs may focus on specific populations (e.g. support for people with eating disorders), specific support types or approaches (e.g. only peer-delivered support), or provide a broad range of services for people with a variety of needs. Service models may include co-management, co-facilitation, and co-location arrangements with other services and organisations, which aims to improve integration between mental health settings and across health and social service sectors. Some key service types offered by the sector include non-clinical psychosocial support, wellbeing promotion services, alternatives to emergency crisis support, step-up step-down services, headspace (for young people aged 12–25 years), Head to Health (adult mental health and navigation services), advocacy services, clubhouses, services for CALD communities or people from refugee backgrounds, and NDIS psychosocial supports. Some non-government organisations are also able to offer clinical services, under a range of different service models. Further details of these key service offerings are outlined in Table 1.

Table 1: *Snapshot of service offerings of the non-government community mental health sector. Please note that this list is not exhaustive.*

Service model and funding	Service types
Mental Health Community Support Services: Non-clinical, psychosocial support services funded by the state government, for people with a severe mental illness aged 18 years or over, who are accessing (or recently accessed) clinical care through the HHS.	*Individual Recovery Support Program*: Individuals are supported to address needs identified in an Individual Recovery Plan; 3-month intensive support followed by 9-month lower intensity support that integrates with group-based support. *Individual Recovery Support Transition from Correctional Facilities Program*: For individuals being released from a correctional facility and referred by Prison Mental Health; 3-month intensive support followed by 9-month lower intensity support that integrates with group-based support. *Individuals at Risk of Homelessness Program*: Individuals must reside in a boarding house, crisis accommodation or hostel; 3-month intensive support followed by 9-month lower intensity support that integrates with group-based support. *Group-Based Peer Recovery Support Program*: Activities led and self-managed by peer workers that complement individual support. Available for 12 months and integrated with individual support programs.
Alternatives to Emergency: 'Safe Spaces' or 'Crisis Support Spaces' provide non-clinical support intended as an alternative to emergency departments for people experiencing a mental health crisis or thoughts of suicide.	Predominantly peer-led support for people presenting to emergency who are in distress, these services are generally open outside usual work hours (e.g. until 9 pm). These non-clinical models offer a more welcoming space for people during a crisis, and include information provision, safety planning, and linkages with other suitable services depending on individual circumstances.
Step-up Step-down: Sub-acute residential service co-delivered by NGO and HHSs, funded by the state government; youth and adult models commissioned in different areas.	Community bed-based residential services available for people transitioning from hospital care to community dwellings, or for community-based people who temporarily require more intensive support. Step-up Step-down services are available for up to 28 days, and staffed 24/7 by NGOs and HHSs providing clinical and non-clinical psychosocial support.
headspace: Early intervention mental health service for young people aged 12–25; blended funding model involving PHN commissioning and Medicare billing.	headspace centres provide access to a range of health professionals, such as general practitioners, psychologists, social workers, counsellors, occupational therapists, youth workers, alcohol and drug workers, peer workers and Aboriginal health workers. Each centre is administered by an NGO and offers unique services depending on local needs and resources available.

Service model and funding	Service types
Head to Health: Different from the 'Head to Health' digital gateway, adult mental health centres offering intake, assessment, care provision and service navigation by multidisciplinary teams; federally funded via PHN commissioning.	Support for people in crisis or significant distress or at risk of suicide. A central point for service navigation and information provision to support access to services based on a holistic assessment of need; offering short-to-medium term evidence-based care for people with moderate to high mental health needs. NGOs administer Head to Health centres, and the phased roll-out of these services is in process at the time of this report.
Clubhouses: Clubs where people with mental health issues can connect for social inclusion, recreation, education and employment support, and peer participation; funded through a combination of NDIS and state government funding.	Clubhouses focus on holistic support for social inclusion and meaningful activity, including supporting education and training opportunities, work experience and supported employment. Clubhouses follow an international model based on relationships between staff and members built on cooperation and consensus-based decision-making on all important matters related to Clubhouse running.
National Disability Insurance Scheme: Support for people under 65 years of age who have a permanent and significant disability. Federal funding is provided on a fee-for-service basis.	For people with a psychosocial disability causing permanent impairment, an NDIS support package may be available. Once a comprehensive eligibility process is completed, eligible individuals develop a plan and source the relevant services that NGOs may provide, supported by a Local Area Coordinator.
Primary Health Networks (PHNs)	Each PHN commissions community mental health services (through a 'stepped care approach') to address service gaps in the priority areas ranging from low intensity mental health services through to services for people with severe mental illness. While this multidisciplinary approach includes funding GPs, psychiatrists and mental health nurses, it also includes the non-government community mental health sector. The National Psychosocial Support Measure (NPS-M) and Continuity of Support (CoS) are two programs funded via PHN commissioning. These recovery-oriented psychosocial supports are offered to people with severe mental illness whose needs are not being met by the NDIS or other state and Commonwealth-funded support programs. NPS-M is time-limited whereas the CoS program provides support for as long as needed.

Funding of the non-government community mental health sector

NGOs are funded at both a federal level (through the NDIA and PHNs) and a state level (through Queensland Health).

The NDIA funds supports for people who are assessed as having a psychosocial disability likely to be lifelong and causing significant impact on their ability to carry out day-to-day activities. There are currently 60,864 participants receiving funded packages through the NDIS at an average annual cost of $68,200.[33] Importantly, the NDIS Minister has indicated that the government expects to divert 27,000 people to outside supports in the next four years, who would have otherwise joined the scheme.
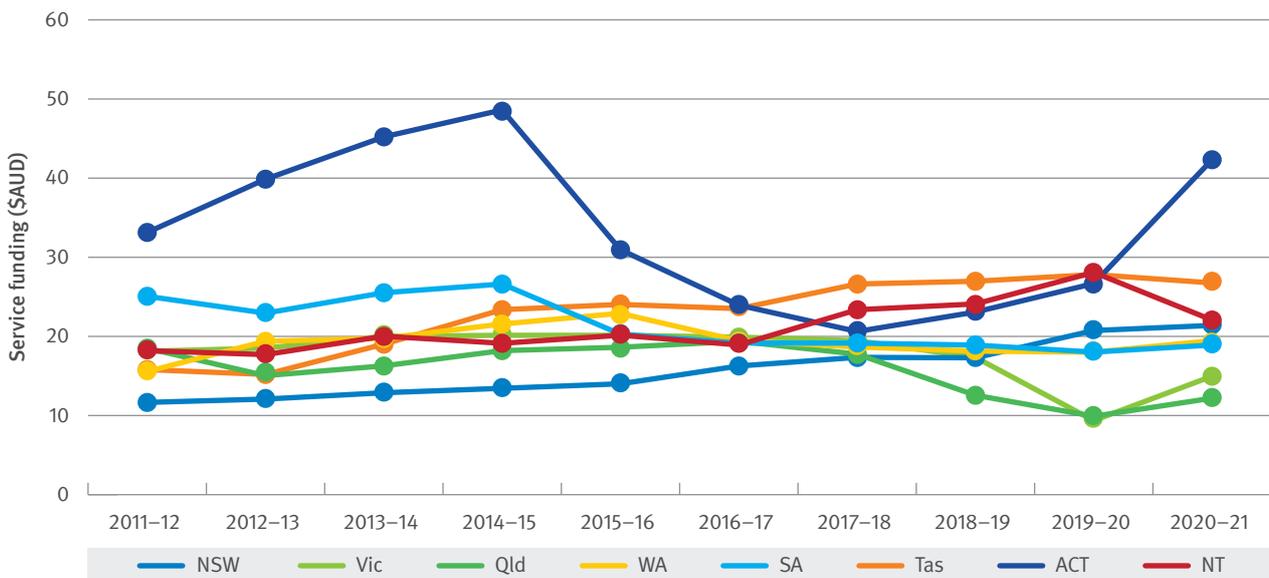
PHNs across Australia have adopted the stepped care model, which offers a spectrum of service interventions. In implementing a stepped care approach in their region, each PHN is required to undertake their own mental health needs assessment and joint regional planning processes to determine the local service needs. PHNs are provided with specific mental health funding to commission psychosocial disability support services and community supports such as peer support, daily living support, social participation or lifestyle interventions.[34]

Queensland Health funds community support services which provide individual recovery and peer support programs, group-based peer support, programs for people at risk of homelessness, and people transitioning from acute mental health wards or correctional centres. It also funds specialist and state-wide programs including advocacy services, clubhouses, Aboriginal and Torres Strait Islander social and emotional wellbeing services, CALD services, family and carers support, and perinatal and infant mental health services. In 2020–21, Queensland spent $63.6 million on the non-government community mental health sector.[35] This equates to just $12.19 per capita compared to a nationwide spend of $17.99 per capita. Queensland would need to increase its spending by 48 per cent to bring it into line with national levels. This represents the lowest investment in the non-government community mental health sector of any state and territory, despite Queensland having a widely dispersed population which is likely to cost more to service (Figure 3). The level of investment in Queensland should increase as a result of the recent $1.645 billion announced by the Queensland government for investment in mental health, however further resourcing to grow and position the sector to meet community need now, and into the future is required.

The proportion of total mental health expenditure spent on the non-government community mental health sector in Queensland is also the lowest of any state or territory (4.7 per cent of total expenditure compared to 6.6 per cent nationwide). By comparison, New Zealand who have set a 20–25 per cent target for total spending on psychosocial supports, report far fewer emergency department presentations, admissions, readmissions and inpatient days.[36]

Figure 3: *State and Territory NGO mental health service funding*

Sources: ABS (2022) Estimated Resident Population by State and Territory 2022; and Productivity Commission (2023) Report on Government Services (RoGs), Part E Section 13 Services for Mental Health.

Evaluations of programs provided in the non-government community mental health sector

Like other components of the mental health system, the non-government community mental health sector is not subject to systematic evaluation of supports and services. Rather, ad hoc evaluations are undertaken for discrete programs, usually retrospectively, using external consultancy firms and with an emphasis on whether funding should be continued. These have included positive evaluations of Queensland programs such as P300, Housing and Support Program (HASP), Floresco Toowoomba, Transitional Recovery Program and the Transition from Corrections program.

Despite these challenges, the Productivity Commission in its 2020 *Mental Health Inquiry Report*, and the *Parliamentary Inquiry into the Opportunities to Improve Mental Health Outcomes for Queenslanders* have called for a more robust evaluation framework. It should be noted that the *National Mental Health and Suicide Prevention Agreement* did commit to "the development of a National Evaluation Framework within the first twelve months", however, there is no public information available at the time of writing this report.

The challenges faced in systematically evaluating programs within the sector are numerous:

- **Lack of consensus on outcome measures:** Evaluations tend to rely on simplistic clinical measures such as the Kessler Psychological Distress Scale (K10) or Depression Anxiety and Stress Scale (DASS-21) which focus on mental illness rather than wellbeing. There is a broad opinion that we need to move away from these measures however designing a new way to capture quantitative data has to date remained elusive.

- **Fragmented data collection systems:** NGOs use a wide variety of digital systems which makes it challenging to aggregate data. Queensland Health have recently released their *Digital Information Strategy 2022–2027* which aims to better integrate information.

- **Lack of individual tracking:** Current data does not allow for outcomes (e.g. emergency department presentations, hospital readmissions) to be compared between individuals who have accessed different services. Data remains aggregated and not attached to unique identifiers which would allow this capability.

- **Contracts do not include funding for evaluation:** While most NGOs are contractually required to report on demographics, outputs and program staffing numbers, no additional funding is provided for systematic evaluation of programs.

- **Administrative burden:** NGOs report being overwhelmed by reporting, compliance and data collection requirements. This administrative burden limits available time for contact with consumers.

A summary of the two recent larger evaluations of the non-government community mental health sector is presented here.

Mental Health Community Support Services Evaluation

In 2020, Queensland Health commissioned the Queensland Centre for Mental Health Research (QCMHR) and the University of Queensland's School of Public Health to evaluate the Mental Health Community Support Services (MH CSS) — the non-clinical, recovery-focused psychosocial support services delivered one-to-one, peer-to-peer or as a group for people with severe mental illness. The aim was to assess efficacy and make recommendations for service improvement.

Overall, the results were positive, finding that "MH CSS programs are vital in supporting people with severe mental illness in their recovery in the community, who would otherwise not be supported".[37] Observed outcomes of consumers engaging with the MH CSS programs included improved relationships, increased confidence, increased quality of life, and in some instances, a return to work. Consumers valued the genuine person-centred and compassionate interactions, mutual sharing of lived experience between staff and consumers alike, strong community networks for connecting consumers, and clear communication about processes and expectations.

Challenges included ambiguous referral processes, low levels of respect from HHS staff, poor handover of care when consumers transition from HHS to NGO settings, and referral pathways exclusive to consumers of HHSs (excluding primary care). Other challenges included workforce issues (capacity, high staff turnover, insufficient training, role clarity) and limited access and resourcing in regional areas.

Specific recommendations included:

- **Referrals** — clarifying the inclusion/exclusion criteria; extending the opportunity for GPs and private clinicians to refer.

- **Strengthening partnerships between HHSs and NGOs** — co-location, regular governance meetings, communities of practice and regular NGO-delivered psychosocial support education to HHS staff, open communication to ensure warm handovers.

- **Data** — expansion of details captured including number of consumers referred, demographic variables (i.e. ethnicity), tracking of individual level data outcomes (i.e. readmissions), more frequent (i.e. at 3-months, 6-months, 9-months, 12-months, exit, and post-exit) collection of standardised, evidence-based outcome measures.

- **Workforce** — reviewing the skills, experience and training required by recovery support staff at all levels, including peer workers, and better aligning the breadth of skills, experience and training required for support workers on specialised programs.

Evaluation of National Psychosocial Support Programs

In 2021, the Australian Department of Health commissioned Nous Group to evaluate the appropriateness, effectiveness, efficiency and impact of two federally funded programs integral to the non-government community mental health sector – the National Psychosocial Support Measure and the Continuity of Support program. These programs were introduced in 2019, as the nation transitioned to the NDIS and historic programs such as PHaMs and PIR ceased. They are implemented through the PHNs who commission NGOs to deliver recovery-based supports for people whose needs are not being met by the existing Commonwealth programs, the NDIS, or state and territory psychosocial support programs.

Generally, consumers reported high satisfaction with these programs. The evaluation consulted with over 500 consumers, carers and family members, the majority of whom were "overwhelmingly positive about the support provided by the programs".[38]

Challenges included short funding cycles, high staff turnover, a poorly qualified workforce, and strict time-limited eligibility which didn't account for fluctuating needs. The ongoing challenge to collaborate and integrate services was well-documented. While integration did occasionally occur, it relied on dedicated individuals and strong local partnerships rather than systemic structures. While tailoring the programs to meet local needs was seen as a strength, substantial program variation across different PHNs led to fragmentation of service delivery. Adding to this fragmentation was funding and governance split across all levels of government which resulted in dispersed accountability and poor incentives for cross-jurisdictional collaboration.

There were also significant problems identified with data collection (using inappropriate outcomes measures such as K10, lack of ability to track individual consumer outcomes such as hospital readmissions). "The data limitations resulted from inadequate governance and inconsistent consent arrangements leading to inaccurate and incomplete data, a lack of consistent outcome data across the programs and the inability to link program usage data with other national datasets."

While the evaluation found that available evidence informs many aspects of program delivery "the level of evidence across these support types varies in volume and quality".

There are some areas where the evidence could be drawn on more heavily to improve the outcomes, as indicated in the following recommendations:

- **Funding** — longer contract length (five years) and longer lead times (nine to 12 months).

- **Data** — adoption of a more fit-for-purpose outcomes assessment tool, and clear and regular assessment points during programs to "support recovery, discourage dependence on services and inform better exit processes".

- **Workforce** — incentives that help to attract a stable and well qualified workforce through competitive wages, conditions, training, support and job stability.

- **Transitions** — greater attention to managing transitions in services to achieve smooth handovers without gaps in service – exiting the service should be expected and agreed upon with consumers.

- **Integration** — strengthened cooperation and mechanisms for collaboration between the PHNs and the state or territory health services, particularly the state regional health networks, are needed to avoid gaps and duplication, and ensure broad coverage across Australia.

- **Recovery-oriented** — goal based, time-limited support with easy and rapid re-entry as needed.

- **Flexibility** — tailored support and services to match the changing needs of individuals (either group and/or individual support across a range of support types).
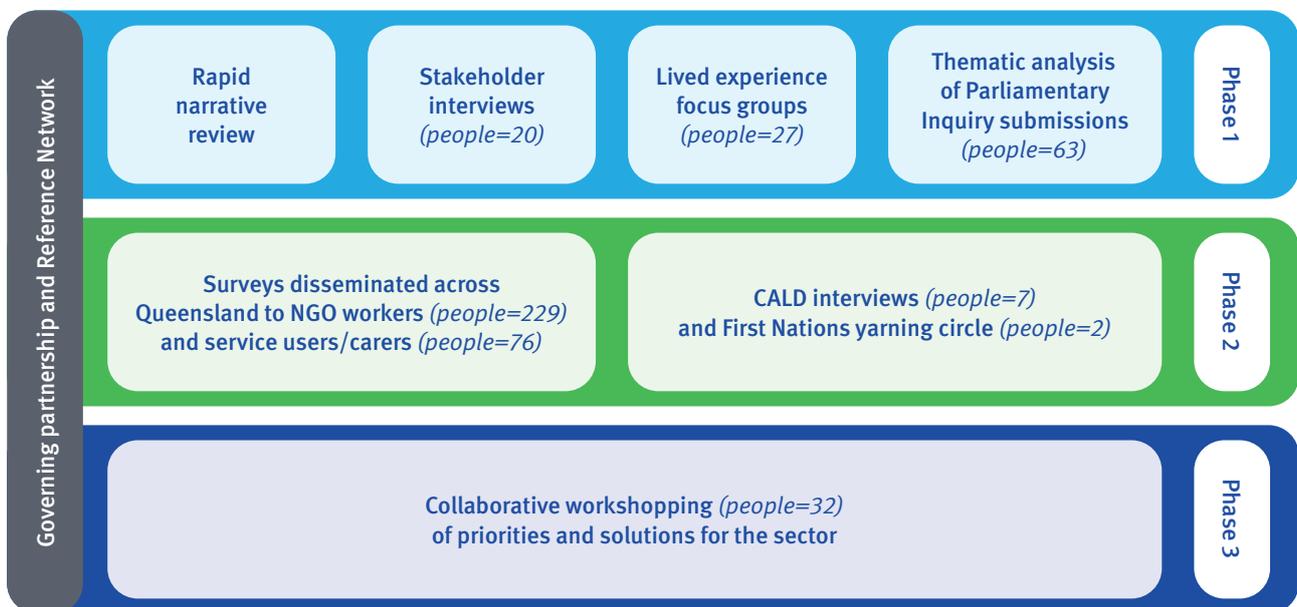
Methodology

The Commission and QAMH engaged Griffith University and QIMR Berghofer to conduct research to identify the strengths, weaknesses, opportunities and challenges facing the non-government community mental health sector. The research team used a rapid narrative review, combined with interviews, focus groups and surveys to capture a range of qualitative and quantitative data. Targeted interviews with people from CALD backgrounds and a yarning circle for Aboriginal and Torres Strait Islander peoples were also included in qualitative data collection. The *Parliamentary Inquiry into the Opportunities to Improve Mental Health Outcomes for Queenslanders* was held during the early stages of this systematic analysis. This rich source of evidence was utilised with the research team conducting a thematic analysis of all submissions from a lived experience or NGO mental health service provider perspective.

A Reference Network comprising people with lived experience as well as representatives from NGOs and the broader health and social services sectors was established. The research team itself included lived experience researchers and academics, some of whom were connected to First Nations and CALD communities. Reference Network members were invited to four meetings at key points throughout the project, with sub-committees overseeing different data collection components. A final workshop was held to review information and identify solutions.

The project was conducted using a three-phase collaborative process (Figure 4).

Figure 4: *Overview of methods*

The Governing partnership involved QAMH and the Commission, and a Reference Network including NGO representatives and people with lived experience. Phase 1 involved a scoping review, interviews, and focus groups with NGO staff and people with lived experience. Phase 2 involved the development and dissemination of a survey based on Phase 1 findings and additional qualitative investigation with priority groups. Phase 3 was a final workshop where findings were presented to the members of the Governing partnership and focus group participants for review and development of solutions and priorities.

Phase 1

Phase 1 included the following activities:

- A rapid narrative review of Australian and international literature in addition to analysis of population and outcomes data at state-wide and regional levels.

- Focus groups with people with a lived experience of accessing NGO support or carers/family members (27 participants) and interviews with NGO staff (20 participants).

- Thematic analysis of submissions to the *Parliamentary Inquiry into the Opportunities to Improve Mental Health Outcomes for Queenslanders*.

Phase 2

Phase 2 involved development and dissemination of surveys through electronic state-wide networks (e.g. emails, website), and focus groups with people from CALD backgrounds and Aboriginal and Torres Strait Islander peoples.

- The lived experience survey aimed to understand experiences of accessing NGO services and whether people received the services they thought would be helpful to them.

- The NGO staff survey aimed to understand differences in service delivery across different areas (e.g. metro vs regional), the perceived challenges and opportunities, and priorities for sector reform.

- To address potential language and cultural barriers, supplementary qualitative methods were used to better understand the service experiences of people from CALD backgrounds and Aboriginal and Torres Strait Islander peoples.

Phase 3

- A final workshop with Reference Network members and focus group participants was held to review findings, develop solutions and agree on future success measures.

- An online activity in Padlet was developed to obtain further input to establish priorities.

Ethics approval for the project was granted by the Griffith University Human Research Ethics Committee (GU Ref No: 2022/136).

Limitations

Recruitment for the surveys was lower than anticipated and, despite significant attempts to reach vulnerable population groups, may not represent the broader population of consumers and staff. In particular, respondents were mainly English-speaking, Australian-born, cis-gender, heterosexual, and did not identify as Aboriginal and/or Torres Strait Islander. Additionally, although the project has benefited from the engagement of the Aboriginal and Torres Strait Islander Community Controlled Health Organisation (ATSICCHO) sector and multicultural services through the project Reference Network, engagement of First Nations and CALD service users was in the end, limited.

Results

Experiences of service provision

Overall, survey data indicated that NGOs succeed in providing humanistic and person-centred support. 82 per cent of staff agreed that the sector provided safe and respectful services for consumers. 85 per cent agreed that their place of work encouraged trauma-informed, culturally safe, family inclusive, lived experience and diversity-aware practices, and 77 per cent agreed that these values were embodied by their supervisors and management.

Current consumers strongly agreed that NGOs treated them with respect and dignity, that they felt safe and welcomed, their confidentiality and individual rights were respected, and that any concerns they had were taken seriously. It should be noted however that past consumers and carers rated these items lower.

These sentiments are supported by evidence provided to the Queensland Mental Health Inquiry.

The only shining light in this very dark period was contacting a mental health organisation (NGO)... It is the reason we are now living healthy, active, social lives, keeping us out of hospital and jail, engaging us in voluntary and paid work, and living in suitable housing (Submission 32).[39]

[The organisation] provides person-centred care in communities where people live. Key to this is encouraging relationships and connectedness, fostering hope, promoting physical health and supporting self-management which helps people to remain at home (Submission 123).

Consumers were also asked about the types of support they would like to address their social and emotional wellbeing needs and if the NGO sector met these needs (Table 2). The top five most needed support types related to the 'Mind and Emotions' domain, with over 90 per cent of respondents needing support to help them heal and grow from traumatic experiences, manage stress, appreciate their strengths and self-worth, find meaning and purpose in life, and make peace with challenging things that have happened. The most needed support types were also in the top five *met needs*, reflecting the strength of the sector in providing person-centred approaches and contributing to their communities' social and emotional wellbeing.

However, there were still many *unmet needs*. For example, 95 per cent of respondents wanted support to discover or re-discover meaning and purpose in life but this need was unmet in 46 per cent of cases. For every 100 people, more than 50 reported not receiving the support they needed to participate in community activities and recreation, improve relationships and social circles, be physically active and eat healthier.

All submissions for the Inquiry into the opportunities to improve mental health outcomes for Queenslanders can be found here: **https://www.parliament.qld.gov.au/Work-of-Committees/Committees/Committee-Details? cid=226&id=4143#sbm-3999c725-847b-43e0-91e6-f07e21435cbd**

Table 2: *Need and unmet need for different types of NGO support*

SEWB domain	Support types	Needed	Met need	Unmet need
		(% of sample)	*(number of people in every 100)*	
	Highest met need			
Mind and Emotions	...appreciate your strengths and improve self-esteem and self-worth	95%	69	26
	...develop good ways to manage stress and stressful events	97%	60	37
	...heal and grow from traumatic experiences	97%	55	42
	...understand and make peace with challenging things that may have happened to you	92%	52	40
	...discover or re-discover meaning and purpose in life	95%	49	46
	Highest unmet need			
Family and Kinship	...have good relationships with friends and develop new friendships and social circles	84%	32	52
Body	...be physically active and eat healthy and nutritious food	76%	25	51
Community	...participate in community activities, recreation, or events with friends, family or kinships	89%	39	51
Spirit and Ancestors	...explore the impacts of traumatic things that may have happened in history to your ancestors or culture	51%	3	49
Country	...enjoy the outdoors, green space, sunlight, and connection with country and the environment	78%	32	47
Mind and Emotions	...understand and organise your care and support from different organisations or services	65%	18	47

Note: The top 5 most needed support types also had the highest 'met need'.

'Needed' corresponds with the proportion of respondents who reported that the support type would help them; 'Met need' is the proportion of those needing support who reported receiving the support in a way that helped them; 'Unmet' need is the proportion of those needing support who reported not receiving it or receiving it in an unhelpful way.

Access to services

Low visibility of the sector

Definitions of the non-government community mental health sector are varied, and confusion regarding the role and identity of the NGO sector remains. Lack of awareness and concerns about the safety and appropriateness of services can prevent people from engaging with mental health and wellbeing support when needed.

Whole of system reform is required in Queensland…this will require recognising the value of psychosocial supports provided by community mental health organisation, and the role they play in the continuum of care, along with greater investment in supports which keep people well in the community (Submission 79).

For some grant-funded services there is an established pathway into community-based services but referral directly from GPs is not widespread. This may be because of a distinct lack of knowledge of the existence of these services by clinicians and historical practices established within the Better Access Initiative (Submission 119).

Stigma and discrimination

Systemic stigma and discrimination were cited as significant barriers to accessing services, with people reporting they did not want others to know they were seeking services, contributing to poorer mental health outcomes. This was particularly true for people seeking help in rural areas and small communities where, for example, people might recognise someone's car parked outside a service provider's building. Consumers also had concerns about seeing NGO staff in their community and how this impacted confidentiality.

Concerns about privacy and confidentiality add to this resistance. Word travels fast in small communities and privacy can be a key concern, particularly if staff are 'locals'. People may worry about being 'labelled' by local gossip (Submission 41).

Geographic maldistribution of services

Another key barrier to access was geographic maldistribution of services. Queensland's vast and diverse geography and lack of public transportation posed challenges for individuals to access services, with rural and remote communities unable to access services close to home and in a timely manner. While telehealth and fly-in fly-out services provided some benefit, it was made clear that they are not the whole solution. Submissions to the Queensland Mental Health Inquiry believed that providing access to services closer to home could better encourage help-seeking behaviours.

We would like to see a system in Queensland that invests in placing services in the communities where people live (Submission 123).

Strict eligibility criteria

Reliance on strict eligibility criteria such as clinical diagnoses and medical referrals was also seen as a significant barrier to accessing services.

The 'no wrong door policy' that underpins the National Mental Health and Suicide Prevention Plan refers to the expectation that all people who make contact with the mental health system will either receive a direct response or be linked to an appropriate service in a timely manner. In reality people with lived experience report that despite 'reaching out' and making contact with the mental health system, they remain locked out of services whose funding models are attached to excessive exclusion criteria (Submission 119).

Complexity of the system

The complexity of the system was a particular barrier to access. Carers and consumers described the need to self-navigate, often through complex service delivery models. They identified restricted hours of service operation, inadequate referral processes and pathways, and inappropriate support as the main challenges when accessing and navigating services.

We've got to go and like jump through multiple hoops and climb through windows and access things online and then advocate for those services and referrals ourselves (focus group participant).

It wasn't just consumers who felt confused by the complexity. The fragmentation and lack of communication has led to referral challenges for NGO staff too. Submissions demonstrated that it was difficult for providers to understand the service provision (including service offerings and availability) of other non-government community mental health service providers when the environment kept changing and there was a lack of formalised communication pathways. In particular, this lack of understanding limited the referral options to known services. It was stated that GPs were more likely to refer patients to psychologists under the Australian Government's Better Access Initiative, possibly because it was more well-known and had established referral pathways. People felt a clearer referral system for the non-government mental health sector would increase patients being directed towards these services.

One of the biggest issues faced by providers however in a constantly changing environment is maintaining their knowledge about other services within the sector, what they do, their availability (including catchment limitations as well as wait times) and how to source these. There are limits to how much individual workers and agencies can do in a siloed system to make their own communication pathways (Submission 41).

NDIS and service gaps

Submissions indicated that in transitioning to NDIS funding, services were forced to focus on providing supports for those with approved NDIS packages. This shift has resulted in people with mental health difficulties not being able to access services when needed. Sometimes termed the 'missing middle' — people whose mental health difficulties are too severe for primary care but not severe enough to receive services in the HHS or a funded NDIS package — this cohort is experiencing real gaps in service delivery.

Unfortunately, since NDIS came in, many communities' mental health services have lost their funding, and we've seen [name withheld] as an example or one of the contributing factors to why they are no longer functioning. And there is a large gap still to be filled (focus group participant).

Many Queenslanders with severe and complex mental health conditions are not eligible for the NDIS and they are missing out on support right now because there are not enough services available in the community (Submission 88).

The non-government community mental health sector was felt to be central to addressing this challenge, with calls for greater investment in psychosocial supports for those falling through the gaps in service delivery.

We encourage the Queensland Government to advocate to the Federal Government to commit to funding psychosocial supports in the community and clarify responsibility for delivery of supports outside of the National Disability Insurance Scheme (Submission 79).

In this submission, we propose a solution to the gap in psychosocial supports through the creation of a National Psychosocial Support Program to provide psychosocial supports to everyone who needs them (Submission 88).

Lack of culturally appropriate services

Finally, a lack of culturally appropriate services was reported as a significant barrier to access. Participants from CALD backgrounds identified discrimination, lack of cultural understanding, lack of diversity and impersonal treatment preventing them from engaging in help-seeking behaviours.

The fear mainly they talk about is "I don't understand the system, I don't know how it works, I don't know how they're going to receive me. I have limited English, and I won't be able to express myself" (CALD interviewee).

Practical barriers also exist to prevent access and participation. These include: Previous negative experiences with health care professionals including perceived lack of knowledge and empathy about the refugee experience (Submission 86).

People's past experience of torture and trauma at the hands of authority figures overseas (including medical personnel) means that there can be significant reluctance to engage with formal services, especially if they are not felt to be culturally safe (Submission 86).

CALD participants (both consumers and NGO staff) also spoke of the additional shame, stigma and discrimination within their communities, which form substantial barriers to help-seeking. This was particularly pertinent for people from refugee backgrounds who may have been subjected to torture and trauma.

For him [father], accepting a support worker is a big shame – like he can't, he will be concerned if anyone from the community knew about it (focus group participant).

Aboriginal and Torres Strait Islander participants also identified difficulty accessing culturally safe and responsive services. Previous interactions with services in the context of historical and ongoing colonisation, including the forced removal of children, lack of self-determination and structural racism also impact a person's willingness to seek services.

First Nations people continue to experience poor mental health and barriers to access at much more significant levels than the general population. Their experiences of marginalisation and intergenerational trauma necessitate investment in more accessible, culturally safe and appropriate services to support Aboriginal and Torres Strait Islander communities, particularly in regional and remote locations across Australia (Submission 66).

Member Services acknowledged the challenges of understanding the current need and impact of mental health for Aboriginal and Torres Strait Islander people and outlined a desire to explore more effective holistic measures that are meaningful and useful at the local level and led by the ATSICCHO sector (Submission 127).

A holistic understanding of mental health and wellbeing that centres on Aboriginal and Torres Strait Islander identity, values and needs should be embedded through the mental health system and supported with culturally safe care in all settings to drive health equity and improve outcomes (Submission 127).

Young people identifying as being from First Nations or Culturally and Linguistically Diverse backgrounds can struggle to find suitable and available services that take into consideration their culture and the role it should play in supporting mental health needs (Submission 74).

Workforce

Workforce shortages

Workforce shortages and difficulties recruiting skilled workers across the sector, particularly in regional, rural and remote locations, was widely reported. These shortages were thought to impact the quality and safety of service delivery. The high staff turnover also had flow-on effects that negatively impacted relationships with clinical services and service users.

Workforce availability is particularly problematic in regional and rural areas, where there are insufficient numbers of staff to service the communities, and where staff turnover is also high (Submission 107).

Survey respondents identified a number of contributing factors to this failure to attract and retain workers. 54 per cent felt that funding models and processes did not support workforce stability and growth to meet demand. Further, most NGO staff believed that the working conditions (e.g. job opportunities, employment stability, staff wages) were not conducive to attracting and maintaining a quality workforce (53–58 per cent). Additionally, staff felt there were limited job opportunities or pathways for career progression and that they were not valued equally compared with other mental health settings.

Short contracts, job insecurity due to tender processes and the introduction of the NDIS are leading to high turnover rates. Professional development, quality assurance and upskilling are often not funded in models, making the community mental health sector a less attractive place to work (Submission 79).

Workforce capability

The need to strengthen workforce capability was reported, in particular building skills to provide evidence-based practices using approaches that incorporate person-led, holistic, trauma-informed, and compassionate care. While the sector already has a strong foundation in these approaches, continual improvement requires professional development and supervision to be embedded in funding and service models. The need to have skills to manage an increasing complexity of presentations was also reported (including increased diversity of population). Workforce development in these areas should be driven by co-design (with staff, consumers and carers) and by fostering greater workforce diversity to improve cultural safety and responsiveness.

Worker wellbeing

Overall, most respondents (76 per cent) agreed that the sector enabled NGOs to provide safe and respectful environments for staff. However, there was a sense that more could be done to address staff wellbeing, particularly in managing workplace bullying and occupational violence (36 per cent did not agree this was done well), and mitigating the impact of stress, fatigue, burnout and vicarious trauma (44 per cent did not agree this was done well).

Lived experience workforce

Both NGO staff and lived experience participants valued the peer workforce. Lived experience participants described this workforce as central to minimising power imbalances through reciprocal and mutual relationships.

Employing peer workers in the mental health system significantly resets the balance of power and advances greater equity, rights, and justice for parents and families (Submission 102).

Effective peer workers engage well in conversation, allowing people to share their story, being authentic within a relationship, and walking steps together with people, as opposed to a clinician talking over you, telling you what you should and shouldn't be doing. I think if there were more places for mental health peer work and more role models … then we would see real change (focus group participant).

Those who reported working or volunteering in lived experience roles agreed that they felt included as an equal team member and that NGOs valued lived experience and peer work (score = 7.9 and 7.8 out of 10, respectively). However, a lower score was found when asked if NGOs provided appropriate support to develop the lived experience workforces (score 6.3/10). This aligns with the focus group recommendations that further training and support for sustainable development of the lived experience workforces are needed. Queensland Mental Health Inquiry submissions echoed this, noting the lived experience workforce is not being utilised to its full potential, with a lack of professional development opportunities, career progression pathways and equitable pay scales.

Quality of NGO supports provided: staff perceptions

An organisation's quality of supports is directly influenced by workforce capability, culture, capacity, governance processes, collaboration between services, infrastructure (built and digital), staff development, leadership, quality improvement processes, and employment conditions.[40] All these components were individually assessed in surveys and focus groups, with quality of NGO supports receiving a 'moderate' score overall. Specific quality components were rated more strongly than others.

Staff felt that NGOs have good working relationships with other organisations and services and that there was a strong culture of continual quality improvement supported by leadership. Workforce capability was rated highly, with staff reporting that they were encouraged to employ evidence-based practice. There was a sense that NGOs managed governance well, with clear processes for escalating concerns and addressing risks, and streamlined internal processes. NGO staff perceived that their leaders inspired staff toward the organisation's mission, modelled ethical integrity, embodied humanistic values, built team cohesion and morale, supported staff to seek innovative solutions, and recognised individual achievements.

Areas for improvement included the need to better promote staff wellbeing to foster mentally healthy workplaces and mitigate stress, fatigue and burnout. There were also lower scores for staff development and capacity building, with 'ability to operate efficiently to meet demand sustainably' receiving the lowest rating overall. Investing in supervision, professional development, career pathways and capacity building to manage workloads was seen as essential to improve the quality of supports provided. Respondents also felt that despite organisational leaders supporting strong engagement with consumers, NGOs could foster better partnerships with people with lived experience when implementing service changes.

Figure 5: *Organisational influences on quality of support*

Quality of support (represented by the grey circle) is directly influenced by workforce capability, culture, capacity, governance processes, and collaboration between services. More distal or indirect influences include support and infrastructure (built and digital), staff development, leadership, quality improvement processes, and employment conditions. Note, each component has been scored as the proportion of survey respondents who answered positively for all survey questions related to each component (possible range 0 to 1; blue>0.6; green=0.4–0.6; grey <0.4).

Lived experience led

Only 63 per cent of NGO staff agreed that NGOs partner with people with lived experience to implement service changes. 66 per cent of NGO staff did not agree that people with lived experience were genuinely involved in determining funding priorities and 58 per cent did not agree that communities were meaningfully engaged in long-term planning.

More than half (54 per cent) of the consumers and carers surveyed expressed a desire to work in partnership with NGOs to improve services. Of the 32 per cent who had been involved in service improvement with NGOs, only half were paid for their time.

NGO staff identified barriers to co-design, including inflexible contractual requirements with unrealistic timeframes and the need to genuinely embed people with lived experience in strategic layers of commissioning and leadership positions.

I guess the next biggest thing for the lived experience workforce is succession planning ... So there's a lot of work to be done in providing greater opportunities for people with lived experience to get exposure to all those different things that are happening at that governmental level or at that high strategic policy level (Stakeholder interviewee).

Numerous submissions to the Queensland Mental Health Inquiry discussed the importance of incorporating the expertise of people with lived experiences in service planning and delivery, beyond tokenistic consultation, in order to effect real mental health sector reform.

To truly address stigma and build trust, services must move beyond tokenistic consultation of those with a lived experience and practice integrated governance (Submission 98).

To begin the process for improving mental health outcomes for Queenslanders, it is fundamental that Governments listen and acknowledge the experience and expertise of lived experience from the beginning of the process, not just as a tokenistic afterthought at the conclusion (Submission 123).

Carer involvement and consultation could become a standardised part of practice and models across organisations and branches. This would ensure carers and people with lived experience are consistently part of codesign from the beginning to the end of processes and not just occasionally included in focus groups (Submission 101).

Service integration

Improved cross-system coordination was recommended in multiple Queensland Mental Health Inquiry submissions. Many advocated for the government to foster better integration both between different services within the non-government community mental health sector, and more broadly between the mental health and other systems, particularly the social services system.

We need a far greater interface between mental health and other service systems to ensure a comprehensive approach to funding, planning and service delivery (Submission 79).

The mental health system was also criticised for focusing exclusively on a person's mental health state, while overlooking the importance of social and economic determinants of mental health and wellbeing, such as housing, social supports, education and employment. Funding models, in particular the fee-for-service model, were blamed for this siloed approach where the broader context of a person's life is not addressed.

The traditional approach to mental health is siloed and does not account for mental health intersecting with other critical issues, such as unstable housing, out-of-home care, low education attainment, long-term unemployment, offending behaviour, substance misuse, domestic and family violence, and other trauma (Submission 74).

Queensland Health has increasingly focused on mental health funding to support individuals – a transactional approach where someone is paid to provide an individual service to someone else (regardless of whether this is provided in the public, private or not for profit sectors). Yet this approach is not designed to solve the problems that often engender and escalate poor mental health problems – isolation, loneliness, uncertainty, relationship problems, distress, anxiety, depression, lack of control and powerlessness (Submission 98).

Provision of safe and secure housing in particular was highlighted as an area in need of better integrated services. It was highlighted that appropriate psychosocial supports, such as wrap around supports and case management services, were required to ensure residents with mental health challenges were able to maintain stable housing.

The Queensland Government should ensure housing stock allocated for people experiencing or recovering from mental ill-health be accompanied by the provision of support from a specialist mental health organisation (Submission 79).

This need to work cross-sectorally in policy, planning and service design and delivery was further explored in the survey. Respondents who identified as being in upper management positions were asked about different service integration strategies employed by their NGO. Three different integration strategies were identified as being utilised within the sector:
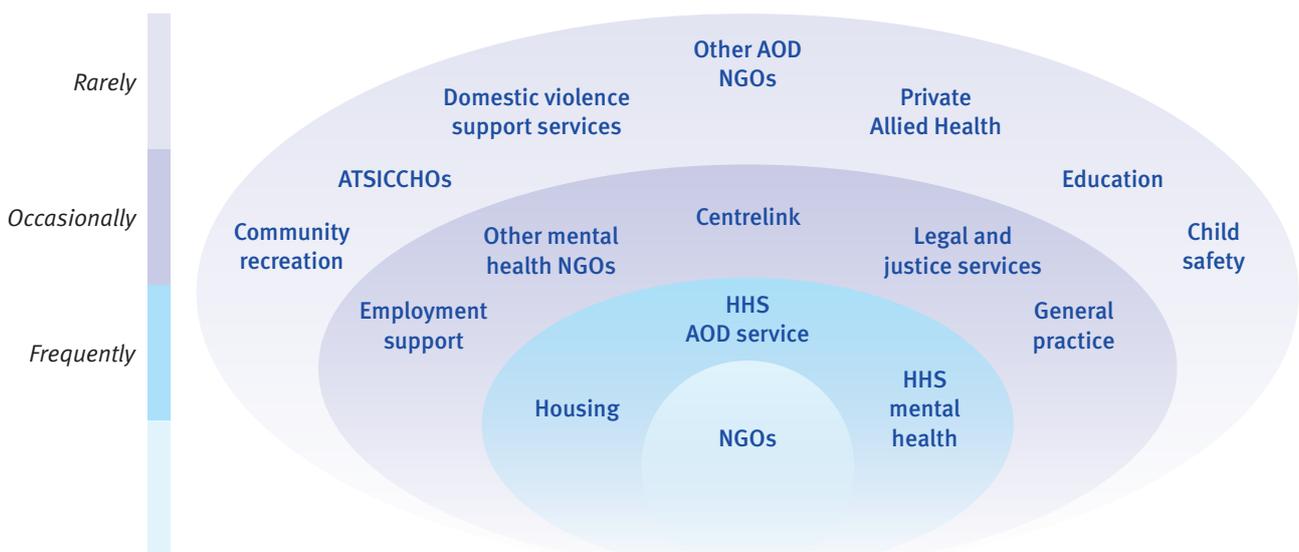
- **Operational agreements** — where processes for working arrangements between parties are embedded.
- **Co-location** — where staff from two different services work in the same space.
- **Staff integration** — where staff from two different services collaboratively plan, coordinate and co-deliver care for consumers.

Managers were also asked if any integration strategies were part of a service contract or included the shared use of data systems for consumer information management.

- **Service contracts** — State-funded services such as the Way Back Support Service, Step-up Step-down Transitional Housing, and Community Sub-acute Transition and Recovery Service, as well as consortium arrangements.
- **Shared data systems** — Entering information in Medicare records with general practice, allied health, and other NGOs; using Qld Health database (CIMHA) for HHS mental health services; and using a shared data exchange system (DEX) to integrate with child services for reporting.

While there are clearly examples of service integration already occurring within the sector, the success of these was felt to be determined by a number of factors such as the preferences and needs of consumers, the capacity and capability of staff, funding opportunities, service contract requirements, and ground-level relationships between organisations. Therefore, any system-wide approach to integration must allow for flexibility and adaptability.

Figure 6: *Integration with NGOs and other service types*

Circles represent the degree of coordination between NGOs and different service and organisation types. Strategies for coordination include referral, 'warm' referral, and facilitating consumer involvement.

NGO: non-government organisation; HHS: Hospital and Health Service; AOD: alcohol and other drug; ATSICCHO: Aboriginal and Torres Strait Islander Community Controlled Organisation.

Joint planning and commissioning

Submissions to the Queensland Mental Health Inquiry felt that unaligned priorities, plans and frameworks at the federal, state and local levels of government have led to governance and coordination challenges. This has resulted in inconsistency, inefficiency, service gaps and duplication of resources. Although some partnerships at the local level were identified (mostly based on strong individual relationships), greater structural guidance was needed to embed collaboration in planning and resources distribution. There are fragmented funding sources across all levels of government with limited intersectoral planning or integration. Submissions called for adoption of a whole-of-government approach, thoughtful planning of services and collaborative funding processes.

In particular, despite Queensland PHNs having undertaken joint regional planning activities with their HHS partners, opportunities for joint commissioning are yet to be fully realised. There is a spectrum of shared activities from joint commissioning that may be considered, from shared service planning through to shared funding contributions (Submission 107).

Geographical fragmentation of commissioning under PHNs also creates inequity and inefficiencies across the state. Individual PHNs may be engaging in similar initiatives to others in the state, such as funding additional complex or advanced care programs. But these are often developed and organised independently of each other, risking duplicative re-invention rather than sharing across PHNs or between hospital and health services (Submission 66).

Funding

Survey data found that most NGO staff felt current funding models do not allow services to provide as much support as consumers need (64 per cent), for as long as they need it (67 per cent), or support workforce stability and growth to meet demand (54 per cent). Sustainability of service provision was a particular concern, with only 58 per cent of respondents agreeing that funding models covered the basic operating expenses, and only 57 per cent agreeing that they enabled NGOs to maintain essential support services (e.g. information technology, human resources, professional development and supervision).

Short contracts with inadequate lead time

The short-term nature of funding, along with the inadequate lead times for contract renewal, was also thought to negatively impact sustainability. Queensland Mental Health Inquiry submissions noted that unstable and short-term funding led to uncertainty in service provision, low staff satisfaction and high staff turnover, difficulty in future planning and limitations in what services providers were able to offer.

Short term funding agreements in community mental health and psychosocial services are leading to 'short termism', including introducing a degree of uncertainty in terms of the longevity of programs (Submission 66).

Without longer funding cycles, community managed mental health organisations such as [the organisation] will continue to experience high staff turnover, lack of permanent employees, and an inability to implement any lasting service delivery changes (Submission 123).

Non-government organisations require more certainty around funding so that they can reduce the burden of mental illness on the acute mental health system and build more robust systems of support. This should include a rolling funding schedule whereby organisations have certainty about employment of staff, rather than being notified of funding decisions in a relatively short period prior to contracts expiring (Submission 98).

Inflexibility

Funding models were also criticised for their lack of flexibility, with the one-size-fits-all model unable to meet regional community needs, encourage local design or foster innovation. 62 per cent of survey respondents reported that funding processes did not provide flexibility for NGOs to influence contracts to better meet community need.

Flexibility in funding to respond to current and emerging local needs is vital. PHNs and HHS' need to be supported to implement innovative responses to manage these emerging needs, while building an evidence base as it's being implemented (Submission 87).

Siloed, hyper-competitive funding

NGO staff reported that competition for funding has led to siloed operations and limited collaboration between organisations. When asked about funding models, most NGO staff did not agree that current funding processes facilitated collaboration across organisations (56 per cent). Queensland Mental Health Inquiry submissions also highlighted that funding needs to be restructured to encourage partnerships and collaboration, with current models only perpetuating fragmentation.

The Queensland Government should fund services in a manner which encourages partnership, to ensure Queenslanders have continuity of care and face fewer barriers to accessing services where their needs may stretch across multiple systems (Submission 79).

Because everyone sees it as a competition, that's why I think it probably needs a third party that's not directly involved to bring us together (focus group participant).

Prevention and early intervention

Many responses emphasised the need for funders to shift focus to prevention and early intervention, by adopting a wellbeing approach. A common theme was the crisis-driven, reactive nature of the mental health system, which focuses on people who are acutely unwell rather than promoting mental wellbeing and early intervention.

The current system focuses on specialist intervention rather than prevention and early intervention, and primarily on adults and adolescents rather than children (Submission 87).

Resources are really going into the treatment end, you know, clinical intervention end. We really need to be focusing on prevention and early intervention (Stakeholder interviewee).

Central to this problem is the domination of the medical model and elevation of clinical services, which are directed at the treatment of illness, over non-clinical community supports with their focus on wellbeing.

It [the mental health system] remains dominated by a medical model, and it has exacerbated experiences of isolation and indifference for people who experience poor mental health, their families and carers (Submission 123).

Submissions argued that mental health should be viewed as a universal concern that required a whole-of-community approach that incorporates prevention and early intervention. Social participation and social connection were felt to be protective factors for better mental health and it was highlighted that the non-government community mental health sector could be instrumental in promoting social connection.

We need to steer away from targeting 'high risk' groups, to position mental health as a universal concern for all community members, supported by a continuum of services (Submission 41).

Psychosocial supports should be available to all consumers regardless of the severity of their symptoms (Submission 79).

Preventative care and support prior to mental ill-health is a critical component of the care continuum (Submission 97).

Community-based supports which are group-based and rooted in social practices were identified as meaningful ways to facilitate connection and belonging, celebrate diversity and inclusion, and support the development of trusting relationships. Community was seen as a place where healing, sustained recovery and personal development take place. Attention to building community and interconnectedness was seen as essential, as was a reorienting resources to focus on promotion, prevention and early intervention.

There is overwhelming evidence about the healing power of building social connectedness – humans are social creatures and need to connect with others ... it takes a community to enable people to fulfil their lives and opportunities (Submission 98).

Evidence-based practice and evaluation

While there was widespread recognition of the importance of consistent service evaluation across the sector to support the value of the sector, there was also concern regarding existing evaluation processes used in the sector. Most survey respondents reported that funding processes did not use indicators that reflected meaningful improvements in consumer outcomes (62 per cent) or use consistent outcome measures across different regions and settings (55 per cent). Submissions reported that evaluations were not included in funding arrangements, with services out of pocket for any time spent collecting outcomes measures and other required data. They felt that developing consistency in outcome measures across different service types and settings would enable large-scale evaluations which could highlight return on investment, drive evidence informed policy, and direct future resourcing. At a service-level it would enable evidence-based practice, with data informing service delivery.

There is a need for greater governance in mental health services, particularly arrangements which enable measurement of effectiveness, outcomes, and which hold services accountable for delivering high-quality services (Submission 79).

Develop evaluation processes to determine effectiveness and impact of services in addition to service safety and quality (Submission 107).

Identified priorities for the sector

To develop recommendations for reform, NGO staff were asked to rate the importance of 26 different priorities for the NGO sector. Responses demonstrated a strong preference for workforce development with two-thirds of the 'critical priorities' related to workforce. Particular issues included improving the working conditions of the sector (job stability, career pathways and salary scales), embedding professional supervision as routine, and building workforce capability in humanistic approaches, evidence-based practice, therapies and funding. Supporting workforce diversity (e.g. lived experience, neurodiversity and diversity of culture, gender and sexuality) was also identified. Other critical priorities related to addressing regional inequality, embedding meaningful co-design, continual quality improvement, and stable funding that recognises NGO infrastructure and overheads.

Sector development and change were seen as 'major priorities'. These included better addressing intergenerational issues, working towards a long-term vision for the sector, developing a stronger unified voice when lobbying for change, and embedding strategic lived experience leadership roles. Additionally, the need for service integration and collaboration between other NGOs, health and social services, and the broader community was also reported.

Respondents likely perceived priorities classified as long-term as being more distant from the sector's immediate issues. Implementing leadership pathways for NGO staff was the most endorsed long-term priority, with supporting NGO growth and development and enforcing accreditation standards for NGOs as the next most endorsed items. While long-term priorities are important, they may be more effectively implemented when core workforce issues, lived experience leadership, quality improvement, service integration, and stability in funding for the NGO sector are addressed.

Key success imperatives

This report outlines a strategy for a stronger NGO community mental health sector with stable foundations and a more unified approach over the next five years. Progress towards this vision begins with leveraging existing opportunities and identified strengths in the short-medium term. It identifies the success imperatives as sector visibility and identity, lived experience, data and evaluation, integration and coordination, funding reform, workforce development and innovative community-based responses. Successes from these initial years can be built upon in the mid-long term to develop sector sustainability, efficiency and a stronger voice in the mental health ecosystem. These longer-term initiatives rely on a more consolidated sector to facilitate important shifts in the stability, visibility and reach of the sector.

Key success imperatives for the non-government community mental health sector

Strategic focus	Short term (1–3 years)			Medium term (4–5 years)	
	1	2	3	4	5
Success imperatives: sector visibility and identity — Valued and visible part of the mental health system					
Further develop the Unique Value Proposition (UVP) to articulate and socialise the value of the sector.	▨	▨	▨		
Awareness raising of the value of the sector specifically targeting government agencies, frontline service providers across sectors, funding bodies, policy makers, broader social services sector, and service users including families and carers.	▨	▨	▨		
Work with relevant stakeholders to refine agreement on sector definition, scope and language.	▨	▨	▨		
Partner with state and national mental health peak bodies for a stronger unified voice.	▨	▨	▨	▨	▨
Success imperatives: lived experience — Lived Experience and co-design is embedded in priority setting, planning, program design, implementation and evaluation					
Implement co-design guidelines, lived experience developed frameworks and training to improve organisational capability to engage people with lived experience in governance, service design, delivery, and evaluation.	▨	▨	▨	▨	▨
Success imperatives: data and evidence — Building data and evidence to drive high quality practice					
Develop a Queensland NGO Outcome Framework which is co-designed by lived experience and includes: • standardised methodology across the sector • meaningful, culturally appropriate outcomes which are determined by the person and regularly reported • data linkage across systems and sectors.	▨	▨	▨		
Implement the Queensland NGO Outcomes Framework.				▨	▨
Establish a data management system that integrates with other components of the mental health and health system.				▨	▨
Support and build the capacity and capability of the sector for quality evaluation and research that further develops the evidence such as through: • forming research partnerships across sectors, services and academic institutions • creating career pathways in research • enhancing opportunities for focused research and evaluation into community mental health and wellbeing • increase availability of research to inform policy and practice.	▨	▨	▨	▨	▨

Strategic focus	Short term (1–3 years)			Medium term (4–5 years)	
	1	2	3	4	5
Success imperatives: integration and coordination — Services and sectors work together for better wellbeing outcomes					
Ensure the NGO sector is meaningfully involved in existing and new regional planning mechanisms to strengthen cross sector planning and service delivery.	▓	▓	▓		
Contribute to consultation on national guidelines for standardised, transparent, evidence-based co-commissioning practices that adhere to a nationally agreed framework.	▓				
Increase collaboration within the sector through shared training and development opportunities.	▓	▓	▓	▓	▓
Strengthen partnerships and increase collaboration with other parts of the broader health and human services system such as co-location of services, shared governance, communities of practice and joint training opportunities.	▓	▓	▓	▓	▓
Remove the barriers to intra-sector collaboration to enable initiatives such as joint staff appointments, co-location, capacity building, shared corporate support systems.	▓	▓	▓	▓	▓
Success imperatives: funding — Contract amounts and specifications reflect the real costs of quality service delivery					
• Develop a standardised costing model including a 'true cost' proposal for utilisation in commissioning processes incorporating operational overheads, indexation, competitive wages and conditions for staff, supervision costs, professional development opportunities and evaluation. • Ensuring the costing model is used as a funding benchmark when developing contracts. • Increase standard length of contracts to five yearly, with adequate lead time guaranteed and options for recurrent funding based on performance. • Ensure contracts include adequate time and funding to enable genuine co-design with people with lived experience. • Support flexibility and innovation in service provision to meet service user's needs based on evaluation and research (including types of services, and mode of service delivery).	▓	▓	▓		
Build the confidence and capability of the philanthropic and corporate sector to invest in the community mental health and wellbeing sector.	▓	▓	▓	▓	▓
Incrementally increase investment towards community-based supports across the spectrum of need.	▓	▓	▓	▓	▓
Increase investment in prevention and early intervention in the non-government community mental health sector.	▓	▓	▓	▓	▓
Support completion of National Agreement's commitment to conduct a gap analysis of psychosocial services outside the NDIS to ensure Queensland's needs are reflected.	▓				
Develop a strategy with adequate funding to address identified gap in psychosocial services outside the NDIS.	▓	▓	▓		

Strategic focus	Short term (1–3 years)			Medium term (4–5 years)	
	1	2	3	4	5
Success imperatives: workforce development The workforce is equipped with the skills and knowledge to provide high quality services to people in the community					
Support the implementation and evaluation of the Community Mental Health and Wellbeing Workforce Strategy.					
Develop and implement the Core Competency Framework for the sector, incorporating both universal and advanced competencies.					
Support organisations seeking to operationalise the Lived Experience Workforce Guidelines (national and state).					
Success imperatives: innovative community based responses Services are available for people to access in the community when they need it without a medical referral					
Trial, evaluate, and support the wider uptake of innovative approaches that exemplify best practice for community mental health.					
Position the non-government community mental health sector to deliver social prescribing programs in Queensland.					

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