



SUBMISSION TO THE PRODUCTIVITY COMMISSION INQUIRY INTO MENTAL HEALTH

"Strong, inclusive and resilient mental health communities."

To the Productivity Commission,

SUBMISSION: Inquiry into Mental Health

Queensland Alliance for Mental Health (QAMH) is pleased to provide this submission to the Productivity Commission (PC).

QAMH is the peak body for the community mental health sector in Queensland. We represent more than 130 organisations and stakeholders involved in the delivery of community mental health services across the state. At a federal level, we collaborate with Community Mental Health Australia, and we work alongside our members to build capacity, and to advocate on their behalf on issues which impact their operations and people experiencing mental health issues in our community.

We support the PC's Inquiry into the role of improving mental health to support economic participation and enhancing productivity and economic growth. The following submission supports our consultation with Presiding Commissioner Dr Stephen King that was held on 14 February 2019. QAMH's submission is also substantiated by research, and most importantly, the input of our member organisations across Queensland.

The main topics we wish to cover in this submission include:

- Rural, regional and remote issues
- Mental health workforce
- Housing and homelessness
- Mental health issues in the justice system

In our advocacy and work that we do in this sector, QAMH supports the Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan (2018 – 2023).

There needs to be the strengthening of coordination between clinical mental health, alcohol and other drugs, physical health, psychosocial, housing, disability and employment supports and services, across public, private and non-government sectors. All these elements form part of an ecosystem to sustain a mentally well nation.

QAMH strongly believes that an increased focus on the support for people with mental health conditions will result to a positive step towards a nation that is happy, resilient and ready to contribute to the economic growth of Australia, which aligns with Mental Health Australia's vision in its KPMG report, Investing to Save – The Economic Benefits for Australian of Investment in Mental Health Reform.

On behalf of the Queensland community mental health sector, and those with lived experience, we thank you for the opportunity to respond to this inquiry.

Yours sincerely,

Jacklyn Whybrow

Acting Chief Executive Officer

Introduction

QAMH is the peak body for the community mental health sector in Queensland. We represent more than 130 organisations and stakeholders involved in the delivery of community mental health services across the state.

At a federal level, we collaborate with Community Mental Health Australia, and we work alongside our members to build capacity, and to advocate on their behalf on issues which impact their operations, and people experiencing mental health issues in our community.

We support the PC's Inquiry into the role of improving mental health to support economic participation and enhancing productivity and economic growth.

The main topics we wish to cover in this submission include:

- Rural, regional and remote issues
- Mental health workforce
- Housing and homelessness
- Mental health issues in the justice system

In our advocacy and work that we do in this sector, QAMH supports Queensland Mental Health Commission's ***Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan (2018 – 2023)***, and its three key areas of focus: Better Lives (Individuals), Invest to Save (Populations), and a Whole-of-System Improvement (Systems).

QAMH strongly believes that an increased focus on the support for people with mental health conditions will result to a positive step towards a nation that is happy, resilient and ready to contribute to the economic growth of Australia, which aligns with Mental Health Australia's vision in its KPMG report, ***Investing to Save – The Economic Benefits for Australian of Investment in Mental Health Reform.***

We believe there needs to be a strengthening of coordination between clinical mental health, alcohol and other drugs, physical health, psychosocial, housing, disability and employment supports and services, across public, private and non-government sectors. All these elements form part of an ecosystem to sustain a mentally well nation, and we urge the PC to act now.

Rural, Regional and Remote Issues

Rural and remote Australians access mental health services at a much lower rate

This is a complex situation with many variables impacting on quality mental health services in rural and remote areas. We have identified the following three key variables:

1) Stigma

The issue of stigma was one that was constantly raised in our discussions with members regarding this inquiry. Rural communities have a culture of self-sufficiency and self-reliance¹ which does not lend itself to openly seeking treatment when it might be required.

The lack of anonymity in small rural settings often creates barriers to access due to stigma and privacy. This is demonstrated through examples sent by our members located in rural and remote regions. Some of the issues identified include:

- The need for privacy when everyone is known to each other
- The difficulty in recruiting health professionals to rural areas. Where they are living in the community they are not able to separate their personal life from their rural setting
- People put running their business (such as a farm) before their own personal health

It is important to highlight that a few members reported a reduction in stigma towards accessing mental health in rural settings. There are a variety of organisations doing fantastic work in regional areas to raise awareness about these important issues, however, the stigma still exists.

2) Access to services

Accessibility to services is also a critical part of the problem. Despite about a third of Australians living in regional Australia, around 90 per cent of psychiatrists and two-thirds of mental health practitioners work in major cities². The Fifth Plan also highlights that the rates of mental health professionals decline markedly with remoteness, with only three psychiatrists per 100,000 of population and 30 psychologists per 100,000 of population employed in remote and very remote areas.

General practitioners (GPs) are often the first point of call for people seeking help with a mental illness, however there are barely half the GP services per person in very remote areas as there are in major cities³. A Grattan Institute report found there were less GP services provided outside traditional hours in rural, regional and remote areas, meaning country people were having to wait longer to see a GP⁴. Evidence from the Australian Institute of Health and Welfare (AIHW) shows mental health-related GP encounters in outer regional and remote and very remote communities is occurring at a far lower level than in more populated centres⁵. That same dataset also shows Medicare-subsidised mental health-specific GP services in remote areas are occurring at less than half the rate of major cities - at nearly one fifth the rate of major cities. This data backs up the anecdotal evidence provided by organisations citing the delays in getting appointments, the challenges posed in travelling significant distances to access

health services, juggling these types of appointments with ongoing work commitments (such as running a primary production business) and the cost of accessing these services. There is also a lack of GPs that bulk bill in many communities, which limits the access of low-income workers to mental health care plans. The level of mental health awareness and training among GPs is another contributing factor.

3) Limited options available – a contradiction to the fundamentals of what the NDIS is about

Another issue is the limited, or even lack of options available to people in regional communities. We know that the NDIS, which is being rolled out across Australia, is about choice and control for participants, however there is little to no choice and control for rural and remote communities accessing mental health services. If there is only one provider or mental health support service and that service does not work for the individual (for example, it is targeted at a different demographic) then people are left with no other options.

In summary, **stigma, access to services** and **limited options**, discourage individuals from seeking treatment, or if they are seeking treatment, it may reduce their engagement with the service. What this means is that mental health issues will continue to prevail, resulting in a reduced quality of life, and lowering participation in the workforce, or self-employment.

The higher rate of suicide in rural and remote Australia

Sadly, evidence shows suicide rates in remote and very remote areas occur at a much higher rate than major cities. Heartbreakingly, there are particular groups that are acutely impacted:

Men

Australian males between 15 and 45 years of age are in the highest risk category for suicide. Across the country, men are approximately 3 times more likely to take their own life than women, and male farmers are dying by suicide at rates significantly higher than non-farming rural males – the further you move from the coast into regional, rural, and remote Australia, the more that figure climbs. *Queensland Farmers' Federation*⁶

Young men

The rate of suicide among men aged 15-29 years who live outside major cities is almost twice as high as it is in major cities. *National Rural Health Alliance*⁷

Primary producers

In Australia, it has been found that farmers have suicide rates around 1.5 to 2 times higher than the national average. *Queensland Mental Health Commission*⁸

LGBTIQ

As in many parts of Australia, Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people continue to experience stigma and discrimination in the community, including in accessing health services in the NT. Service providers and governments have an important responsibility to

improve understanding and responsiveness to the needs of LGBTI people. *Northern Territory Mental Health Coalition*⁹

Aboriginal and Torres Strait Islander Peoples

Suicide accounted for over 1 in 20 Aboriginal and Torres Strait Islander deaths in 2015 compared to just under 1 in 50 non-Indigenous deaths. *Australian Government*¹⁰

It is clear that a complex range of factors contribute to these higher rates of suicide in rural, remote and regional areas. These are some of the contributing factors that we have identified:

- 1) Ability to access services**
 - i. Lack of specific and inclusive support for at-risk groups such as LGBTIQ people
 - ii. Lack of suitably trained and culturally appropriate services for Aboriginal and Torres Strait Islander peoples
- 2) Easier access to lethal means in country areas**
- 3) The greater pressures faced by primary producers (such as weather conditions, government policy intervention and external factors impacting profitability).**
- 4) Youth unemployment**

Research suggests LGBTIQ people in rural areas face heightened discrimination and abuse and have less access to inclusive mental health services. This leads to higher risks of suicide attempts and suicides.

There are also significant risk factors for Aboriginal and Torres Strait Islander peoples, including discrimination based on race or culture, economic and social disadvantage, physical health, alcohol and substance misuse and interactions with the criminal justice system.

For example, there are a range of unique factors when considering Aboriginal and Torres Strait Islander communities. These include: limited access to suitably trained mental health professionals, a lack of culturally sensitive services that incorporate a holistic conceptualisation of mental health and the impact of alcohol and other substances.

We note the considerable work that is happening regarding regional mental health and suicide prevention plans as a result of the Fifth Plan (particularly Priority Area 4, in relation to the Aboriginal and Torres Strait Islander community). However, we believe to truly address all of these issues an independent rural and regional mental health taskforce focusing on Queensland and the Northern Territory is required.

It's clear the low rates of people accessing mental health services is a contributing factor to the high rates of suicide amongst these cohorts living in regional communities. To address issues in relation to rural suicide the provision of adequate health services should be addressed.

For young people, the lack of employment prospects and economic independence is an issue. The youth unemployment rate in Queensland Outback was 59.1 per cent (at March 2018). The socioeconomic issues faced in rural and regional locations cannot be discounted.

In summary, there is no one-size-fits-all approach to reducing suicide rates in regional communities. A prevention strategy that works in one community, may have very little impact in another.

Geographical distance a barrier to consistent service delivery

The geographical nature of Queensland presents an opportunity for technology to improve service delivery in rural, remote and regional areas. Amongst our members in Queensland, there is a strong support for the role of technology to assist in service delivery.

As highlighted by the Royal Australian and New Zealand College of Psychiatrists, a number of studies have illustrated that telepsychiatry can be as effective as face-to-face consultations¹¹.

Some member organisations we consulted as part of this submission highlighted the benefits of telehealth services as:

- Removing the concern in regional communities that someone will see you walking into a clinic
- Eliminating the concern that the physician you get treatment from, knows your friends/family
- It links people directly to experienced professionals who are also linked to other services (GPs, pharmacists)
- Provides access to a service that a person might not have had access to, or had to travel significant distances for.

However, our members also highlighted the importance of having people who were properly trained and experienced in delivering these types of services. As one member said, “I think the use of appropriate and skilled support workers would be beneficial in this area”.

The way in which these services are delivered is critical to ensuring their increased usage into the future. As these services are rolled out, they need to be used by trained professionals with experience engaging with patients through the use of technology.

Internet access is another critically important part of telehealth services. It is no good providing these services if internet accessibility is so bad that it doesn't allow a continuous connection, or if it becomes too expensive for people to get access to adequate internet services. There is also a lack of internet access for most Aboriginal and Torres Strait Islander people living in remote communities. Any strategy for delivering more telehealth services would need to address the challenge of providing these services in remote Aboriginal and Torres Strait Islander communities.

If individuals have a negative initial experience with telehealth or telepsychiatry services, it will damage the attitudes towards these services. There is great potential for these services to improve access to mental health services in regional locations, but they must be delivered in a measured way.

Continued investment in locally developed, low-intensity treatment options that are culturally and linguistically appropriate, and which build upon local community capacity, are favoured by much of the remote sector. In summary, digital therapies should supplement, but not make redundant, remote, practitioner-based services.

Recommendations

To address the issues identified above, the QAMH recommends the establishment of an independent Queensland rural and regional mental health taskforce.

Queensland is unique when it comes to regional Australia, being the most decentralised state in the nation. For these reasons, our jurisdictions are the right fit for a taskforce to deliver recommendations on improving mental health services in rural and remote locations.

This taskforce should be completely independent from government and be made up of representative organisations from the QAMH.

The independent taskforce would consider all aspects of mental health service delivery, including Commonwealth-funded services, State and Territory Government services, the Primary Health Networks and non-government organisations.

Some of the priority areas for consideration would include:

- Major gaps in services and strategies for addressing these gaps
- Mental health workforce and training development
- Service coordination and integration across government and NGO services

Such a task force would be informed by the collation of PHN service mapping in rural and remote areas and other key datasets.

The independent taskforce would conduct regional hearings across Queensland and could call on government agencies to provide evidence and information as required. It would be established for a period of two-years and be required to provide an interim and final report outlining a key set of recommendations to improve the delivery of mental health services across rural and remote parts of Queensland. The findings of the taskforce would be used to inform strategies in other locations across Australia.

The task force would be funded by the Commonwealth Government. Our organisations would welcome the chance to lead the establishment of this independent taskforce. We would also welcome the chance to discuss this initiative directly with the PC.

We believe the only way the issues identified in this submission will be fully addressed is by engaging mental health service providers and organisations delivering services in regional locations to come up with a well-informed and complete package of recommendations following extensive consultation.

Mental Health Workforce

Nature of the mental health workforce

This is arguably the biggest challenge in providing mental health services to regional communities. Earlier in this submission we identified the low number of GPs, psychologists, psychiatrists and mental health nurses living and working in regional communities. This illustrates the significant challenges in attracting and retaining suitably qualified staff in regional communities. Like all other parts of delivering mental health services in regional communities, there are a complex range of factors that add to the difficulty of retaining suitably trained professionals, including:

- The difficulty in attracting people with the right skills
- The cost of attracting and retaining staff in rural locations
- The inability to keep staff in regional locations for a prolonged period of time
- The need for better professional development programs
- The uncertainty of short-term contracts
- Staff burnout

Anecdotal evidence shows many older health professionals have made their careers living and working in regional communities, but that the vast majority of younger tertiary-qualified professionals coming through the system are moving to regional communities as a way of gaining experience to enable a move back to coastal towns and cities. A range of factors contribute to this churn, particularly the lack of a support network (both personally and professionally), that opportunities for career advancement are not available in rural communities and the burden of extra time and travel to reach patients.

Many non-government organisations providing mental health programs in regional communities highlighted the significant costs in attracting and retaining staff, particularly in remote locations. Uncertainty around government funding contracts only adds to this challenge.

A number of providers identified difficulties in keeping trained and experienced staff in a regional location when there was significant uncertainty over the renewal of funding. These delays can force employees to look for more employment certainty, which can lead to the loss of staff and provide an additional cost to the provider in replacing an employee that has left the organisation. While many government programs may respond to specific community needs (such as the impacts of drought) by investing in additional staff, without ongoing funding it is not possible to embed these professionals in those regions. One of our members particularly noted the challenges in attracting suitably trained staff, especially to remote locations, and that fund providers (for example, government) needed to understand these challenges and the importance of identifying the right person for the role.

Staff burnout is another challenge. According to the Australian Medical Association, rural GPs tend to work longer hours and take on broader tasks¹². Similarly, the Royal Australian and New Zealand College of Psychiatrists has identified the vulnerability of staff to burnout, identifying the need for appropriate professional support¹³.

In some rural and remote regions, the size of the Aboriginal mental health workforce appears to be in decline. There is also a lack of Registered Training Organisations currently delivering culturally appropriate, accessible, accredited mental health training and education.

The challenges of delivering mental health services in the regions

There are many challenges to delivering health services in regional parts of Australia, which have been identified above. These challenges are interrelated. For example – the lack of available staff can cause burnout, which in turn contributes high turnover of health professionals in regional communities. There is also a limited documented scope of practice for psychosocial workforce which impacts the integration between clinical and non-clinical staff.

The current pricing under the NDIS is set below current sector awards - in response, NDIS providers are employing staff without the appropriate qualifications or formal training due to award constraints.

For example, the Social and Community Services Queensland Award states that a psychosocial support worker with a tertiary qualification or Certificate IV, must be paid at level 3 and above.¹⁴ With the current NDIS pricing, these award rates cannot be met. The limited services in smaller communities can lead to longer wait times to access services. Some organisations reported a wait period of at least 10 weeks to access youth counselling services. The delays in being able to access these services can lead to crisis for those individuals seeking treatment and support.

The lack of services in regional areas can also mean individuals have no choice but to travel to larger regional centres to access professional support or for hospitalisation. This requires additional financial and human services. It also means the person is separated from their family and support networks, so appropriate post-vention support is compromised.

Our members have expressed that the casualisation of the mental health workforce has had a negative impact on skills and service delivery. However, this can be overcome through collaboration. It has been observed that in major regional centres such as Townsville, Mount Isa, and Mackay, clinical staff work closely with psychosocial workers and peers. This is due to the following reasons:

- Recognition of the value of non-clinical staff who have the requisite skills in the recovery model
- Organisations driving an approach that is inclusive of a range of workers collaborating with the person impacted by poor mental health. Staff capability and competency frameworks can be utilised within organisations to create opportunity for collaboration.

In more rural areas, for example, Hughenden, a town with a population of just over 1,000 people, specialist psychosocial workers would visit on a regular basis to link with local clinical staff.

For example, consulting with rural communities about having a regular day when visiting services, enabling all to attend at the same time, thus allowing for a virtual one stop shop. Follow-up can be provided via technology. In terms of successful service delivery in rural and remote areas, collaboration and coordination is essential.



In summary, we need to develop a mental health workforce that is sustainable in order to deliver consistent, high quality and recovery oriented mental health services. The need for services remains high, therefore workforce challenges need to be addressed for it to meet the needs of consumers and carers, their families and communities, and giving them the choice and control that is one of the fundamentals behind NDIS.

Housing and Homelessness

Outreach challenges

People with lived experience have greater housing instability, poorer quality of housing and less choice over living conditions than people without a mental illness. In fact, 15 per cent of households on the Housing Register in Queensland (waiting for long-term social housing) were assessed as having difficulty accessing housing due to a member of the household having a mental illness. It is also known that approximately 24 per cent of clients seeking specialist homelessness service assistance were identified as having a mental health issue.¹⁵

The homeless population is a difficult one to reach. Our members suggested that a workforce that is dedicated to the homeless need to be flexible and versatile in terms of work hours, particularly after hours.

The outreach programs do not seem to be moving along despite being a good model, however it can be very successful in some settings where trust and ongoing resourcing are paramount.

Housing First - evidence of a successful housing model

There has been overseas evidence that the Housing First model is successful in improving the housing stability of those living with mental illness. Housing First is an evidence-based model which demonstrates that people need a stable roof over their heads before they need anything else. Physiological needs and safety needs form our basic needs – they are our biological requirements for human survival. They must be satisfied before progressing to meet higher level growth needs.¹⁶

There is strong evidence of success overseas, particularly in Finland with the need for crisis accommodation almost eliminated and just 52 shelter beds in the entire country, down from 600 in 2008. Finland's success has been attributed to a major government investment in social housing, which meant people could be quickly moved off the streets and out of crisis accommodation. According to Professor Eoin O' Sullivan, editor of the European Journal of Homelessness, homelessness is about dysfunctional housing markets and dysfunctional services, rather than dysfunctional individuals. A big part of the solution is around the coordination of services.¹⁷

More importantly, there has also been formal evidence of its success locally in Brisbane. Based on a research commissioned by MICAH Projects, the Housing First approach in Brisbane has been successful. The research projects follow a group of individuals who were experiencing homelessness over a period of three years, who were successfully housed through the Housing First approach.

The research demonstrated that this approach is indeed sustainable and indicated that housing people with support costs less than keeping a person homeless. Cost effectiveness analysis were based on costs of health, legal and allied health service events which were decreased as participants moved from homelessness through an initial year of support to longer-term support, based on the decreasing frequency of legal, drug and alcohol service events.¹⁸

The Housing First project was carried out through the Brisbane Common Ground Initiative at Hope Street, South Brisbane, with MICAH Projects delivering onsite support services, which include holistic case management, mental health, primary healthcare, recreation and other specialist services to prevent people becoming homeless again and to support people to achieve their goals.

One of our members have expressed that the Housing First approach will only be successful should adequate supports and services sit alongside the tenancy to ensure capacity building, independence, and financial management – for example paying rent and bills in a timely manner.

In fact, the Mental Health Australia and KPMG report states that adopting a Housing First model for young people aged 15 to 24 with a mental illness at risk of homelessness will generate \$1.6 billion in short term savings, and \$4.8 billion in long-term savings.¹⁹

There also needs to be cultural consideration for Aboriginal and Torres Strait Islander people in terms of family and kin visiting or staying at the premises. In relation to that, clear boundaries about what is or is not acceptable to maintain family and kinship connections that do no impact on housing sustainability and potential tenancy problems.

Overall it is vital that governments provide more flexible social housing with long term supports available for people who might be in stable accommodation for the first time in their lives and who need intensive tenancy support that tapers off as things improve.

In summary, addressing housing and homeless issues is an investment that will in turn achieve positive health and social outcomes, which is key to increasing workforce participation rate. The stability in having a permanent dwelling satisfies our biological requirement for human survival and improves quality of life. We believe this will encourage the pursuit of gainful employment, even more so if tenants have access to Disability Employment Services. However, this does not address the housing and homelessness issues in regional and remote regions, which are different to issues in urban areas.

Mental Health in the Justice System

One of the strategic priorities of the Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018 – 2023 is working in partnership to expand integrated models of care for those in the criminal justice system through better coordination across areas such as mental health, alcohol and other drugs, housing disability, employment and psychosocial support. We truly believe that the success of a program cannot stand alone, it is a part of an ecosystem, which is what mental health services should represent.

Mental health in the prison population

It is clear from available research that mental illness is highly prevalent amongst the prison population in Queensland. The Criminology Research Council Consultancy found that rates of a wide variety of mental health disorders are disproportionately high within the criminal justice system compared to the general population²⁰.

According to the Australian Institute of Health and Welfare (AIHW) the proportion of prison entrants who have been told by a doctor, psychologist or nurse that they have a mental health disorder is 49%²¹. The AIHW reports that this rate has increased, compared to the last reporting period, and that women are more likely than men to report high levels of distress²².

A 2010 study from the New South Wales Bureau of Crime Statistics and Research (BOCSAR) also found that high rates of mental illnesses and substance use issues have been found amongst prison populations at both the State and National level²³. Walter Sofronoff QC, in the Queensland Parole System Review Final Report (QPSRFR), found that a massive proportion of prisoners suffer from various mental illnesses and that in many cases these illnesses are implicated in the offence that led to imprisonment²⁴. A 2012 study published in the Medical Journal of Australia also found a very high prevalence of mental disorder among Aboriginal and Torres Strait Islander adults in custody²⁵.

When reflecting on this evidence, it's clear that any study looking at imprisonment and recidivism rates in Queensland needs to consider:

- Potential alternatives to imprisonment where the offender has a mental health condition;
- More training to identify pathways for assessment and management of offenders;
- The types of mental health support available to people in prison to support their recovery;
- The discharge process for prisoners with mental health conditions to ensure they continue to receive support, if required;
- The types of services available to assist people re-entering the community after a period of imprisonment to enhance their social participation and reduce rates of reoffending.

Imprisonment rates

QAMH is unaware of any studies that show an increasing rate of imprisonment for non-violent offences amongst people with mental health conditions. However, we make the following observations:

1. That AIHW figures highlight an increasing number of prison entrants who have been told they have a mental health disorder²⁶.
2. That the QPSRFR highlighted the increase in prisoner numbers has also resulted in an increase in the number of prisoner referrals to the Prison Mental Health Service²⁷.

Noting the above information, it stands to reason that an increasing number of people with mental health conditions are being imprisoned for non-violent offences. While the circumstances surrounding individual cases will be different, QAMH believes there should be further consideration of alternatives to prison in these instances. This is in keeping with the view of the World Health Organisation, which states “for people with mental disorders who have been charged with committing minor offences, the introduction of mechanisms to divert them towards mental health services before they reach prison will help to ensure that they receive the treatment they need and also contribute to reducing the prison population”²⁸.

QAMH is mindful the court considers many factors when deciding on a sentence, including custodial and non-custodial sentences. We believe this review is an opportunity to explore a range of non-custodial and other options in appropriate circumstances, such as:

- Alternative sentencing options, inclusive of treatment, for people with identified mental health conditions;
- More targeted and flexible community-based orders which emphasise treatment and rehabilitation as their core component;
- Justice reinvestment strategies that direct funding to community-based initiatives which look to address root causes of crime;
- Expansion of drug court programs, recognising the significant number of adult offenders with mental health conditions; and
- Restorative justice programs for young offenders.

There are a range of potential benefits in adopting these approaches, including: improving the level of treatment provided, which can reduce the likelihood of reoffending; not putting the individual in an environment which can further exacerbate their condition (such as an overcrowded prison); and reducing the cost to the state of imprisoning an individual.

Recent research indicates there is a willingness from the community to accept alternatives to prison. A 2011 paper from Victoria’s Sentencing Advisory Council found the community was open to increasing the use of alternatives to prison, as a policy change. The level of acceptance to alternatives to prison was greatest for mentally ill offenders²⁹.

Community based orders allow people to serve their sentence in the community and include intensive corrections orders and probation. However, the QPSRFR identified restrictions on imposing these orders which may have contributed to courts imposing terms of imprisonment where they feel the community-based orders are inflexible³⁰. It urged consideration of community corrections orders, as used in Victoria. In NSW, a 2017 report from BOCSAR identified a 11%-31% reduction in the odds of reoffending for an offender with an intensive corrections order compared with a prison sentence of up to 24 months³¹. “These results further strengthen the evidence base suggesting that supervision combined with rehabilitation programs can have a significant impact on reoffending rates.”

Justice reinvestment programs are being increasingly used across the world. The design and effectiveness of these programs is explored in a 2018 paper published in the Australian Institute of Criminology³². The paper concludes, “at both the Commonwealth and state and territory levels, Australia is at a point where enthusiasm and support for JR (justice reinvestment) has the potential to manifest into effective and practical strategies which can contribute to lasting outcomes of real social benefit”.

Some examples of initiatives that are making a difference in the community include Life Without Barriers’ Multisystemic Therapy program on Brisbane South and North, which is being delivered through the YouthChoices Social Benefit Bond³³. QAMH members, Sisters Inside do fantastic work helping women who have been criminalised in a range of ways, including work pathways, helping women to readjust after the trauma of being imprisoned and with mental health support services. These services support the objective of having less people in remand through alternative and effective approaches.

Available mental health services in the Queensland prison system

The QPSRFR highlights that the availability and effectiveness of programs, services and interventions for Queensland’s prisoners is an important component of the criminal justice system³⁴. The Review also highlights the services available to prisoners, including access to Queensland Corrective Services psychologists, counsellors and cultural liaison officers. In addition, referrals can also be made to the Queensland Health, Prison Mental Health Service (PMHS). The Review identified the most recent statewide PMHS audit found 11.8% of the prison population were active clients of the PMHS.

QAMH believes the PMHS is invaluable and the service provided in Queensland compares favourably to other Australian jurisdictions. The PMHS plays a significant role in connecting patients with community-based mental health services to ensure reintegration after their release from prison. However, the QPSRFR did make the following points:

- Only 15 per cent of PMHS clients receive the services of the PMHS Transition Coordination Program; and
- Due to long waiting lists, some prisoners are released from custody before even being assessed for mental health treatment by PMHS.

The QPSRFR made recommendations (numbers 24 and 25) that the Queensland Government should review the resourcing of prison and community forensic mental health services and the provision and

resourcing of services for Aboriginal and Torres Strait Islander people and women in the correctional system. The Queensland Government's response supported these recommendations. QAMH believes these findings and the Government's response could help to inform the current review being undertaken by QPC.

QAMH would also draw the PC's attention to the Offender Health Services Governance Improvement Project that is currently being conducted through Queensland Health³⁵. A consumer perspective of the provision of health services in prisons, conducted as part of this review, identified mental health – access and treatment options as one of five key themes. The PC's work may also be informed by some of the initial evidence gathered for this project.

Transitioning back into the community

Queensland Health currently funds the Transition from Correctional Facilities (TFCF) program, which is targeted towards adults with severe and persistent mental illness who are being released from correctional facilities and have been referred by the PMHS. Under this program, non-government providers support individuals in a range of ways, including (but not limited to):

- Accessing ongoing treatment and mental health services;
- Assisting with training and employment opportunities;
- Supporting people to find accommodation;
- Supporting people to live independently; and
- Connecting people to relevant community-based services.

These providers will link in with the PMHS prior to a person's release and ensure continuity of mental health care and other supports from a correctional facility into the community.

An evaluation report into Community Mental Health Transition to Recovery Programs (including the TFCF program), released in 2012, found the programs had resulted in a range of positive outcomes for clients³⁶. A notable outcome was the improved management of mental health issues, evidenced by the shift in service usage away from the acute mental health sector to the community sector.

Some of the key information highlighted in that evaluation report regarding the TFCF program includes:

- The service providers' management and monitoring of relationships with pre-release and post-release stakeholders was seen as crucial to the integrity of the service model;
- Service providers reported that the double stigma of mental illness and a prison background affected access to housing, in particular; and
- It was a specific challenge delivering the program to clients over vast geographical areas.

The evaluation also reported specific cases where clients avoided reincarceration as a result of the program, however the full extent to which the TFCF program impacted recidivism was not assessible from the data.

From a QAMH perspective, this program plays a vital role in ensuring community-based treatment is available to people who need support in making this transition. A range of circumstances may impact recidivism for an individual, but the research makes it clear that when people are supported and continue to receive treatment to address their condition, they are less likely to reoffend.

QAMH is supportive of this program and notes the work of all involved in contributing to its success. This review provides an opportunity to look at expanding these types of community-based supports to help more people exiting the prison system with a diagnosed mental illness.

As highlighted above, there are opportunities to strengthen the referral system for people transitioning back into the community by reducing waiting lists so that fewer prisoners are released into the community before being assessed for treatment and by better coordinating discharge services to ensure that every prisoner with a severe mental illness has a coordinated care plan for their discharge from prison.

There are many benefits to this approach. For example, the 2012 evaluation report into the Transition to Recovery Programs identified a cost of less than \$17,000 per client for the TFCF program. The Issues Paper reports costs of almost \$110,000 per year to keep a person in prison in Queensland. There are obvious cost savings to the State if these people are assisted to stay out of the corrections system. And if more people are assisted to transition back into the community so that they don't reoffend, this can take pressure off the existing prison mental health services – which can reduce waiting times and further improve outcomes.

In summary, by providing mental health support and increasing the availability of services to the prison population, it will allow for a smoother transition back into the community whereby an individual is rehabilitated. This will increase the likelihood of re-joining the community in a meaningful way, including having the opportunity to participate in gainful employment.

We encourage the PC to work in collaboration with the Queensland Productivity Commission to implement recommendations from their inquiry once the final report is released in August 2019.

¹ Vines, R. (2011). Equity in health and wellbeing: Why does regional, rural and remote Australia matter? Australian Psychological Society (2011) InPsych Volume 33. Retrieved from <https://www.psychology.org.au/for-members/publications/inpsych/2011/oct/Equity-in-health-and-wellbeing-Why-does-regional>,

² Brown, P. (2017). Mental health in rural Australia. The Australian Journal of Rural Health 25, pg 258-259.
Doi:10.1111/ajr.12402

³ Duckett, S., Breadon, P., Ginnivan, L. (2013). Access all areas: new solutions for GP shortages in rural Australia. Grattan Institute. Retrieved April 30, 2018 from <https://grattan.edu.au/wp-content/uploads/2014/04/196-Access-All-Areas.pdf>

⁴ Ibid

⁵ Australian Institute of Health and Welfare. (2018). Mental Health Services in Australia, General Practitioners. Retrieved April 30, 2018, from <https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia/specialised-mental-health-care/general-practice>

-
- ⁶ Armitage, S. (2018). Men's rural health under spotlight. Retrieved May 1, 2018, from <https://www.qff.org.au/presidents-column/mens-rural-mental-health-spotlight/>
- ⁷ National Rural Health Alliance Inc. (2017). Mental health in rural and remote Australia: Fact sheet December 2017. Retrieved May 1, 2018 from <http://ruralhealth.org.au/sites/default/files/publications/nrha-mental-health-factsheet-dec-2017.pdf>
- ⁸ Queensland Mental Health Commission. (2013). Snapshot: Farmer suicide in Queensland. Retrieved May 1, 2018 from https://www.qmhc.qld.gov.au/sites/default/files/wp-content/uploads/2013/10/AISRAP-Snapshot_farmers.pdf
- ⁹ Northern Territory Mental Health Coalition. (2017). Northern Territory Mental Health & Suicide Prevention Service Review. Retrieved May 7, 2018, from <https://www.ntmhc.org.au/mental-health-suicide-prevention-service-review-2017/>
- ¹⁰ Commonwealth of Australia. (2017). National Strategic Framework for Aboriginal and Torres Strait Islander Peoples' Mental Health and Social and Emotional Wellbeing. Department of the Prime Minister and Cabinet. Retrieved May 1, 2018 from https://pmc.gov.au/sites/default/files/publications/mhsewb-framework_0.pdf
- ¹¹ Royal Australian and New Zealand College of Psychiatrists. (2018). Telehealth in psychiatry. Retrieved May 1, 2018 from <https://www.ranzcp.org/Publications/Telehealth-in-psychiatry>
- ¹² Australian Medical Association. (2016). A plan for better health care for regional, rural, and remote Australia. Retrieved May 1, 2018 from <https://ama.com.au/system/tdf/documents/AMA%20Plan%20for%20better%20health%20care%20for%20regional%20rural%20and%20remote%20Australia.pdf?file=1&type=node&id=43997>
- ¹³ Royal Australian and New Zealand College of Psychiatrists. (2016). Rural and remote mental health and wellbeing action plan response. Retrieved May 1, 2018 from <https://www.ranzcp.org/Files/Resources/Submissions/RANZCP-QLD-QMHC-Rural-Remote-Submission-27April20.aspx>
- ¹⁴ Fair Work Ombudsman. Social and Community Services Industry Pay Rates. Retrieved April 4, 2019 from <https://www.fairwork.gov.au/pay/minimum-wages/social-and-community-services-industry-pay-rates>
- ¹⁵ Shifting Minds: Queensland Mental Health, Alcohol and Other Drugs Strategic Plan 2018 – 2023. (2018) pg. 13. Retrieved April 1, 2019 from https://www.qmhc.qld.gov.au/sites/default/files/files/qmhc_2018_strategic_plan.pdf
- ¹⁶ Simply Psychology (2018). Retrieved April 1, 2019 from <https://www.simplypsychology.org/maslow.html>
- ¹⁷ William, W 2017. Pro Bono Australia. Retrieved April 1 2019 from <https://probonoaustralia.com.au/news/2017/09/ignoring-social-housing-recipe-failure-expert-warns/>
- ¹⁸ Mason, C, Grimbeek P 2013. Breaking Isolation, Building Community – A Housing First approach to homelessness in Brisbane: Sustaining tenancies and the cost effectiveness of support services. Retrieved April 1, 2019 from https://micahprojects.org.au/assets/docs/Publications/IR_127_A-Housing-First-Approach-to-Homelessness.pdf
- ¹⁹ Investing to Save: The Economic Benefits for Australia of Investment in Mental Health Reform. (2018) Pg. 3. Retrieved March 25 2019 from https://mhaustralia.org/sites/default/files/docs/investing_to_save_may_2018_-kpmg_mental_health_australia.pdf
- ²⁰ Ogloff, J., Rivers, G., Ross, S. 2006. The identification of mental disorders in the criminal justice system. Criminology Research Council Consultancy. Pg 1. Accessed online on 16/10/2018 at - <http://crg.aic.gov.au/reports/2006-ogloff.pdf>
- ²¹ Australian Institute of Health and Welfare. 2015. The health of Australia's prisoners 2015. Cat. no. PHE 207. Canberra. Pg 37. Accessed online on 16/10/2017 at - <https://www.aihw.gov.au/getmedia/9c42d6f3-2631-4452-b0df-9067fd71e33a/aihw-phe-207.pdf.aspx?inline=true>
- ²² Ibid
- ²³ New South Wales Bureau of Crime Statistics and Research. 2010. Comorbid substance and non-substance mental health disorders and re-offending among NSW prisoners. Pg 2. Accessed online on 17/10/2018 at - <https://www.bocsar.nsw.gov.au/Documents/CJB/cjb140.pdf>

-
- ²⁴ Sofronoff, W. 2016. Queensland Parole System Review Final Report November 2016. Pg 8. Accessed online on 17/10/2018 at - <https://parolereview.premiers.qld.gov.au/assets/queensland-parole-system-review-final-report.pdf>
- ²⁵ Heffernan, E et al. 2012. Prevalence of mental illness among Aboriginal and Torres Strait Islander people in Queensland prisons. Accessed online on 17/10/2018 at - https://www.mja.com.au/system/files/issues/197_01_020712/hef11352_fm.pdf
- ²⁶ Australian Institute of Health and Welfare. 2015. The health of Australia's prisoners 2015. Cat. no. PHE 207. Canberra. Pg 36. Accessed online on 16/10/2017 at - <https://www.aihw.gov.au/getmedia/9c42d6f3-2631-4452-b0df-9067fd71e33a/aihw-phe-207.pdf.aspx?inline=true>
- ²⁷ Sofronoff, W. 2016. Queensland Parole System Review Final Report November 2016. Pg 144. Accessed online on 17/10/2018 at - <https://parolereview.premiers.qld.gov.au/assets/queensland-parole-system-review-final-report.pdf>
- ²⁸ Beynon, J., Drew, N. Mental Health and Prisons – Information Sheet. Accessed online on 17/10/2018 at - http://www.who.int/mental_health/policy/mh_in_prison.pdf
- ²⁹ Sentencing Advisory Council, State of Victoria. 2011. Alternatives to Imprisonment: Community Views in Victoria. Page 24. Accessed online on 17/10/2018 at - <https://www.sentencingcouncil.vic.gov.au/sites/default/files/publication-documents/Alternatives%20To%20Imprisonment%20Community%20Views%20In%20Victoria.pdf>
- ³⁰ Sofronoff, W. 2016. Queensland Parole System Review Final Report November 2016. Pg 97. Accessed online on 17/10/2018 at - <https://parolereview.premiers.qld.gov.au/assets/queensland-parole-system-review-final-report.pdf>
- ³¹ Wang, JJ Joanna & Poynton, S. (2017). Intensive correction orders versus short prison sentence: A comparison of re-offending (Crime and Justice Bulletin No. 207). Sydney: NSW Bureau of Crime Statistics and Research.
- ³² Willis M & Kapira M. 2018. Justice reinvestment in Australia: A review of the literature. Research Reports No. 9. Canberra: Australian Institute of Criminology. Accessed online on 18/10/2018 at <https://aic.gov.au/publications/rr/rr09>
- ³³ Queensland Treasury. 2018. Youth Choices Social Benefit Bond. Accessed online on 24/10/2018 at - <https://www.treasury.qld.gov.au/growing-queensland/social-benefit-bonds-pilot-program/youthchoices-social-benefit-bond/>
- ³⁴ Sofronoff, W. 2016. Queensland Parole System Review Final Report November 2016. Pg 142. Accessed online on 17/10/2018 at - <https://parolereview.premiers.qld.gov.au/assets/queensland-parole-system-review-final-report.pdf>
- ³⁵ Clinical Excellence Division, Queensland Health. 2018. Information available at - <https://clinicalexcellence.qld.gov.au/priority-areas/service-improvement/offender-health-project>
- ³⁶ Australian Healthcare Associates. 2012. Evaluation of the Community Mental Health Transition to Recovery Programs. Pg 10. Accessed online on 17/10/2018 at - https://www.ahaconsulting.com.au/wp-content/uploads/2015/07/ttr_final_report_november2012.pdf