COMMUNITY SUPPORT AND SERVICES COMMITTEE

Members present:
Ms CP McMillan MP—Chair
Mr SA Bennett MP
Mr MC Berkman MP
Mr JM Krause MP (virtual)
Ms CL Lui MP
Mr RCJ Skelton MP

Staff present:
Ms L Pretty—Acting Committee Secretary
Ms C Furlong—Assistant Committee Secretary

PUBLIC HEARING—INQUIRY INTO SOCIAL ISOLATION AND LONELINESS IN QUEENSLAND

TRANSCRIPT OF PROCEEDINGS

MONDAY, 11 OCTOBER 2021

Brisbane

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The committee met at 9.32 am.

CHAIR: Good morning. I declare open this public hearing for the Community Support and Services Committee's inquiry into social isolation and loneliness in Queensland. I would like to respectfully acknowledge the traditional custodians of the land on which we meet today and pay our respects to elders past and present. I acknowledge the member for Cook as a First Nations woman and a member of our committee. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander people, whose lands, winds and waters we all share.

On 27 May 2021, the Legislative Assembly agreed to a motion that the Community Support and Services Committee inquire into and report on social isolation and loneliness in Queensland, with a reporting date of 6 December 2021. My name is Corrine McMillan, member for Mansfield and chair of the committee. Mr Stephen Bennett, the member for Burnett, is the deputy chair. The other committee members are: Mr Michael Berkman, member for Maiwar; Mr Jon Krause, member for Scenic Rim, who is on the phone this morning; Ms Cynthia Lui, member for Cook; and Mr Robert Skelton, member for Nicklin.

The purpose of today's hearing is to assist the committee with its inquiry into social isolation and loneliness in Queensland. I ask that any responses to questions taken on notice today are provided to the committee by Monday, 18 October 2021. The committee's proceedings are proceedings of the Queensland parliament and are subject to the standing rules and orders of the parliament. The proceedings are being recorded by Hansard and broadcast live on the parliament's website.

Media may be present and will be subject to the chair's direction at all times. The media rules endorsed by the committee are available from committee staff if required. All those present today should note that it is possible you might be filmed or photographed during the proceedings by media and images may also appear on the parliament's website or social media pages. I ask everyone present to turn mobiles phones off or to silent mode.

Finally, while the current COVID-19 restrictions for South-East Queensland remain in force, all persons present at committee proceedings will be required to wear a face mask, to be removed only when speaking during the proceeding. We will also be adhering to limits on the number of people present in the hearing room today. I thank everyone for their ongoing understanding as we battle this pandemic. The program for today has been published on the committee's webpage, and there are hard copies available from committee staff.

EGAN, Mr Kelly, Chief Executive Officer, Clubs Queensland

NIPPERESS, Mr Dan, General Manager, Clubs Queensland

CHAIR: Good morning and thank you for appearing before the committee today. I invite you to make a brief opening statement, after which committee members will have questions for you.

Mr Nipperess: Clubs Queensland welcomes the invitation by the committee to comment on the inquiry into social isolation and loneliness in Queensland. We will make a brief opening statement to the committee and subsequently be available to answer any questions.

Clubs Queensland is the peak industry body for registered and licensed clubs throughout Queensland. We represent the interests of over 860 registered and licensed clubs from Coolangatta to Cooktown and as far west as Mount Isa, Moranbah and Longreach.

Community clubs in Queensland play a pivotal role in forming the social fabrics of communities. They are all by nature not-for-profit entities and include sporting clubs such as our leagues clubs, AFL, union, soccer, sailing and multisports, our bowls clubs, our golf clubs, importantly our RSL and services clubs, our surf lifesaving clubs across Queensland beaches, as well as a host of other community and cultural clubs.

There exists over 3½ million club memberships across Queensland. As an industry, it employs over 23,000 Queenslanders and is supported by an equal number of volunteers that contribute over $2 billion to the Queensland economy annually.

Queensland's community clubs importantly play a key role in connecting Queenslanders. They are community hubs that provide a meeting place for many people, whether that be catching up for a meal or a drink or enjoying a game of lawn bowls or golf. They are a safe and familiar place for Queensland's elderly to enjoy the company of their friends over affordable hospitality and even a game of bingo. They have a far reach into regional Queensland in remote areas, with most regional centres having a local club. Being not-for-profit entities, they also support thousands upon thousands of sub-clubs including sporting, RSL sub-branches, surf lifesaving clubs and other community and cultural clubs.

It goes without saying that Queensland's community clubs are critical in addressing the issue of social isolation and loneliness in Queensland. With the increased support of the Queensland government, the club industry will continue to be able to sustain and deliver programs that support sport and recreation, community services, culture and community development and, importantly, be there to support those who just need a place to go and interact with others who know their name.

We are of the view that the impacts of COVID-19 have been a catalyst in recognising the impact of social isolation and loneliness for many Queenslanders. During the lockdown last year, clubs across the state conducted extensive welfare checks on their members, continued to provide community services including food deliveries and, upon the staggered reopening, did their best to bring the community back together through their many forms.

Another issue that community clubs are aiming to address is that of elder abuse and family and domestic violence. The club industry for many years has run the 'My Community Club Says Yes to Respect' campaign. This Queensland initiative, running alongside the international 'Ask for Angela' campaign, aims to create safe places for everybody in communities.

Social isolation and loneliness in Queensland is a real issue, and the club industry would be more than willing to contribute further to this discussion about how the drivers and impacts of social isolation can be addressed in a cost-effective manner, leveraging existing infrastructure and programs already in place.

CHAIR: Thank you very much, Dan. I thank the work of Clubs Queensland right across our state in supporting our vulnerable people, particularly those who are socially isolated and lonely.

Mr BENNETT: On 15 September we had a Parliamentary Friends of Clubs Dinner, and Clubs Queensland put on a great evening. At that presentation you particularly got my attention when you were talking about this exact subject. I am curious about the fact that you have so much to offer and I would like to talk about that more this morning. Did you elect not to put in a submission or were you not aware of the inquiry?

Mr Nipperess: We were not aware of the inquiry until I was contacted by the committee secretary. I do thank them for making that contact. We would be more than happy to provide information or make a further submission subsequent to this hearing.

Mr BENNETT: For the committee, can you reiterate what was presented on the 15th, because it is important that Queenslanders understand what Clubs Queensland is doing? You briefly mentioned it in your opening statement, but maybe some more examples would be helpful.

Mr Egan: Thank you kindly for the feedback, Stephen. It was great to have so many of you along to that dinner. We had 50 MPs in the room that evening. It was a very challenging time for you, too. There was a lot of discussion around the Voluntary Assisted Dying Bill. We certainly appreciated your time and effort to be there. Obviously the support of the Premier, and the Leader of the Opposition as well, was very welcome.

The theme of the night was all around the fact that clubs, by design, are the original social hub of a community. Two key words out of that were 'connectivity' and 'community'. We are very fortunate as entities to have our member clubs—of which there are 439 approximately across the state—provide that real substance of support. It was heightened further on the back of the COVID reopening. The Check In Qld app is obviously a very important mechanism in making sure Queenslanders stay safe, and we were instrumental in making sure that that was part of our industry. Based on the anecdotal feedback that we have, the patrons who are entering clubs feel very safe and protected. There is a visible presence around making sure that health is maintained and that there is community support in place the whole time.

Getting back to our Parliamentary Friends of Clubs Dinner, the whole idea of that was to illustrate the fact that, as not-for-profit core purpose entities for the community, we do provide that level of connectivity. We thank the local members in all of those electorates they represent across the state for their support.

Of our membership in particular, 68 per cent of those are in sporting clubs. I think we all understand the value of the role that plays in terms of the people who coach youth, people who mentor youth and the volunteers who assist and are associated with that. The concept of the evening was to highlight the fact that, as much as we have licensed entities operating across the communities of Queensland, the core purpose of those licensed entities is to support community benefit. To that end, we thank all of you for being part of that, and we thank you for the opportunity to present this morning.

Ms LUI: In your opening statement you mentioned that COVID-19 was the catalyst for social isolation and loneliness, and that is something we have heard from other speakers throughout our public hearings. How did your clubs go about engaging members and people in the community to feel more connected and supported at the start of COVID-19?

Mr Egan: That was illustrated significantly when we had our awards dinner in March, which was the first time in a long time that the club industry as a whole had a chance to gather together. There are numerous examples of that across the state. Dan made reference to one club in particular in that the Charleville RSL prepared meals for the community and distributed those meals to senior citizens and citizens of disadvantage across that community.

There are a number of examples that I could give that would replicate that analogy. We are very proud to say that as an industry that was something we were very strongly supportive of. Upon reopening as well, we definitely wanted to give people the opportunity to come back in. We have a demographic that falls into that senior citizen range. Bowls clubs, golf clubs and associated sporting community clubs certainly play a big role in reconnecting people on a social or a competitive basis. Dan, did you have anything to add?

Mr Nipperess: Yes. There are probably two other examples. We comment a lot on the prevalence of senior citizens in Queensland's community clubs. Lawn bowls is a perfect example of that. Just recently with some of the COVID restrictions that came in with limited community sport, while they may seem insignificant to some, the impact that that has across Queensland when you are taking away this one social outing that a lot of people have in their whole week or month can be quite significant. It can impact greatly.

Another really good example is that of Anzac Day this year. In 2020 clubs were not able to hold Anzac Day commemoration ceremonies in particular. In 2021 there were a lot of restrictions to comply with, and community clubs did their very best to bring back those who were part of an RSL sub-branch, returned services veterans who represented Australia. That was really important especially to RSL and services clubs in terms of supporting their community.

Mr BERKMAN: We have heard throughout this inquiry from a lot of neighbourhood and community centres. Obviously they are very different kinds of entities to your members. I am keen to understand better the sorts of services that those neighbourhood and community centres offer, whether it is mental health support services or referral to relevant services. There is a very broad range of needs that they seek to meet with the bit of government funding that they have. I am keen to understand what scope you think there is for clubs to provide similar services. You gave the example of the distribution of meals during COVID lockdown. They are quite discrete examples. Do you believe there is scope for your membership to provide a broader range of either direct services or referrals for members and support those communities more directly?

Mr Egan: As a high-level anecdotal comment, the fact of the matter is that a lot of our licensed clubs do support and provide grants and charitable donations to those entities, not only the cash component but the in-kind component in regard to meeting spaces, function rooms and structured support around being able to identify and deliver those core purposes. I do not have a specific number to attribute to that other than the fact that we know that across the state most of our members have an arm of support to those community entities.

Mr Nipperess: Every club across Queensland is different in terms of their objects. The critical component of it is outside of their core purpose, which for an RSL might be to support the local sub-branch or the Surf Life Saving supporters club to support the surf club on the beach. A lot of them have community benefit programs that operate. Those have extensive reach into supporting charities, men's sheds, local schools, including a whole range of community support grants as well that they provide.

Other targeted assistance is probably more so related to simply being that social meeting hub for many Queenslanders. It is really important in terms of the scope of this inquiry that sporting and that sort of social outing was highlighted by the committee as being a critical element of connecting Queenslanders. That is obviously what our industry strives to do but along the way also giving support to, as Kelly mentioned, a lot of other entities and charities and other not-for-profit organisations.

Mr SKELTON: I have spent the weekend engaging with my clubs. I know of the good work that the Nambour RSL do. They support the veterans and also Equity Works, which supports people with a disability. They do a magnificent job, as you said, with the ancillary funding, providing marquees and meeting spaces et cetera. I was after more information—you might have to give it in a submission—about what clubs you are managing around the state and, as Michael mentioned, about different programs run by different clubs. One thing we have noted with community centres is that they are doing great but it is all a little bit different. Is there some way of seeing what everyone is doing so we can get a bit more uniformity so that it is easier for everybody? Is there a way of getting everyone together, if that makes any sense?

Mr Nipperess: Probably to highlight other examples, if we are going to draw out some of the larger clubs in Queensland, I would like to note Caboolture Sports Club as one of those entities. Caboolture Sports Club is a large sporting organisation and supports around 70-odd subsports across the Caboolture and Moreton Bay region of South-East Queensland. Their community contributions on an annual basis would far exceed a million dollars in terms of what they provide back to the local community and back to community sport.

Going back to what Kelly was saying earlier, the prevalence of sport in Queensland and its importance to Queenslanders, from our children all the way up to our senior citizens, is critical. Those subclubs simply would not exist without the support of the licensed club—in this case, Caboolture Sports Club. That is one large example in South-East Queensland.

If I am to provide other examples, it would be recognising the work that Surf Life Saving supporters clubs do. It is probably a concept that many Queenslanders do not fully understand—how Surf Life Saving Queensland is funded. In addition to the state government funding that is provided, it is the surf club itself that is sitting there. Across Queensland beaches, we would have approximately 60 Surf Life Saving supporters club members on both the Gold and Sunshine coasts as well as all the way up to Cairns. The work these clubs do in terms of keeping Queensland beaches safe is critical.

In terms of the support that other clubs provide, I would like to highlight that of our community and cultural clubs. We have examples such as the German Club at South Brisbane, the Greek Club at West End and a lot of other organisations like that that are simply there to support a particular culture within the community. Again, it is probably a concept that many people do not fully understand in terms of the importance of continuing those particular cultures. That is through really simple things. If I am to take the German Club, it is their dancing schools and their singing schools and generally promoting the German culture in Brisbane. There are so many examples of these discrete clubs that exist across the state.

Mr SKELTON: The German Club is a good example, being October.

Mr Nipperess: Oktoberfest, yes. That was the intention there.

Mr Egan: There is the Polish Club on the Gold Coast. There is a whole raft of those sorts of clubs.

Mr SKELTON: I think you have hit on it, Dan, in the sense that we do not have that understanding. If you could give us some information to read through and share on the work that you are doing, that would be great. I see it at a local level in the hinterland because we are a very tight community. All the clubs help each other out. It is quite good. That does not occur everywhere. If we could get that sort of thing happening, that would be fabulous.

Mr Nipperess: That is not a problem.

Mr BENNETT: While everyone is naming clubs, can I point out that The Waves Sports Club in Bundaberg won the Best Multi Sports Club award and the Club Director of the Year was Tony Castro. For your information, he won the Community Organisation of the Year at our local chamber awards on Saturday night. Now that we have that out of the road, the member for Nicklin made a really good point, in all seriousness. Our inquiry has exposed a lot of organisations trying their best with limited resources all over the state. The point that the member made was about the connectivity and how we can better coordinate and network and provide those services. That is something to look at going forward.

The other point to make is the education award that you have within your organisation and those programs. It must be incredibly tough to judge those. Can you talk about some of the stand-out ones? You would have had multiple entries: Sky's the Limit—Healthy living and positive lifestyle choices, Giving Young Aussies a Fair Go, Education helps with prevention and cancer charities. Are there any outstanding ones that maybe this committee could get some further learnings from?

Mr Egan: We are happy to take that on notice and come back to you in that regard.

Mr BENNETT: Is that all right, Chair?

CHAIR: Yes, absolutely.

Mr SKELTON: There is a lot of information that we need from you. We have probably overloaded you a little bit. It would be great if you could.

Mr Egan: Not at all. We are very pleased to be asked because we know we have a good story to tell there.

Mr BENNETT: Maybe if we just have those half a dozen award recipients, that might narrow it down to make it a bit simpler. Obviously they met a high criteria and were judged to be beneficial. Maybe if we could have those half a dozen good examples of award recipients?

Mr Egan: We are certainly more than happy to provide that. The move towards the whole community core purpose support through those awards and the amendment of some of the criteria of those awards was done intentionally and to further illustrate the effectiveness and the core purpose of community clubs. We are happy to provide that.

Mr BENNETT: That would be much appreciated.

CHAIR: Kelly, in thinking about the demographics of people who are more affected by social isolation and loneliness than others and certainly the demographics that you are aware of, do you see any possibility where the 93 local members across Queensland and other community leaders can work with you a little more closely to identify some strategies to address those demographics? Obviously they may be different for different communities. Is that something that you would consider or think about—identifying some of those groups?

Mr Egan: I think as a community clubs entity we are always looking for the opportunity to engage with government and members within their local electorates. We do that independently on behalf of our members now. Cynthia, apologies—I missed you a few weeks ago when we were in Cairns doing that very thing with Michael Healy and Craig Crawford, who was on leave at the time. We are always looking for those opportunities, Chair. We are certainly more than happy to support that conversation. It is twofold: one, it creates a better link to the community purpose that we are there for, and obviously that is a good conversation to be having; and, secondly, it promotes a great conversation in regard to the direction in which you want to see community supported. We are more than happy. I think independently our clubs are doing that anyway. I know quite of few of you on the panel do that anyway.

CHAIR: Yes, absolutely.

Mr BERKMAN: I am interested in the role that pokies play in clubs. A lot of your members would have a lot of electronic gaming machines, and they rely on that income to various extents for the work they do through their subgroups and whatever other community works are happening. There is no doubt, though, that there is a flip side to that: gambling addiction and the mental health issues that sit alongside that oftentimes have a real impact on a lot of Queenslanders, particularly in the context of social isolation and loneliness. Is Clubs Queensland doing any work directly with its membership to address those impacts and to move towards getting pokies out of clubs for the betterment of Queenslanders and particularly those struggling with gambling?

Mr Egan: Michael, you are correct in your assumption that it does play a role in a revenue value to clubs—as does food, as does beverage, as do events, as do functions. It is one of many components that provide for the business of clubs. Our role as Clubs Queensland is to represent our industry effectively so that their business can continue to benefit clubs and strengthen communities. Electronic gaming machines play a particular role in that, as do the other core purposes of our business.

We are part of a very strong responsible gambling advisory committee. We play a very active role in that, like the Queensland Hotels Association as well. The difference with income derived in community clubs is that it goes back to the community. Without the support of those varied revenue streams, it is very hard for us to support the community to the level that we support it at.

With anything that we approach as an industry to the broader community, particularly with reference to you in regard to electronic gaming machines, there is a perception that it promotes a problem. We recognise, without doubt, that there is a very small problem out there—the same as there is in other areas of gambling and wagering. Our job moving forward is to make sure our club industry is represented strongly in that component to minimise the impact of irresponsible gambling.

Mr BERKMAN: You said just a moment ago that there is a 'very small problem'. Do you mean that there is a small proportion of gamblers who are addicted gamblers as opposed to it being overall a small problem?

Mr Egan: That is correct.

Mr BERKMAN: Is Clubs Queensland doing any work directly in looking to investigate the economic benefits, the flow-on benefits, from pokies revenue as opposed to those direct impacts on individuals and communities to establish that kind of cost-benefit relationship through the impacts of problem gambling and pokies more generally?

Mr Egan: We have a very strong working relationship with the Office of Liquor and Gaming Regulation represented through the Club Compact, which is a team of people from Treasury, OLGR, Attorney-General and ourselves as clubs representing, I guess, where we need to support this and take this. The industry at the moment is in very strong, positive discussions around what harm minimisation is and what it should look like and some of the processes that should support that at this point in time, as it has been for a number of years. Dan, did you have anything more to add?

Mr Nipperess: I think what is important to note as well is the current work that is being done by government through the responsible gambling plan for Queensland 2021-2025. That has been an extensive framework that has been put together by the Attorney-General, Shannon Fentiman, and something that Clubs Queensland has been heavily supporting. Proactively, Clubs Queensland are also going out to explore other ways in which gambling harm can be managed in Queensland. That includes updating various components of Queensland's gambling legislation and the Responsible Gambling Code of Practice as well as looking into how we can facilitate multivenue self-exclusions and other player protections to protect Queenslanders against this potential harm and risk that is caused.

To your question in relation to whether there has been any cost-benefit analysis, as Kelly highlighted, given the nature of community clubs—and they are a category 2 gaming licence holder—100 per cent of any income derived from a gaming machine in a community club needs to be reinvested into the community. When you are looking at that income that is derived by clubs, at least from our industry it is suffice to say that we are very confident that all of that flows back to community, whether to support that community's fundamental objects as an RSL or a surf club or a sporting club or directly back through to the community through their charitable support and their community organisational support such as, like I mentioned earlier, to schools, men's sheds, charities and all those sorts of things.

Mr BERKMAN: Yes, and of course the gambling revenue is coming from the community in the first instance through people who are using the pokies, so there is a flip side to that one too. Very quickly and finally, with regard to any of that work you have referred to, whether it is in collaboration with government or within Clubs Queensland, is any of that specifically addressing the possibility of simply reducing the number of pokies that are available in clubs in Queensland? We know that the sheer exposure to electronic gaming—pokies generally—does have an impact on the proliferation of problem gambling and the impacts that has on the community.

Mr Egan: As a hospitality industry, both clubs and hotels at this point in time do a very good job at maintaining a level of harm minimisation and a very effective level of harm minimisation comparative to other states across Australia, and research indicates that with regard to the actual percentage of problem gambling. We as a peak body certainly recognise that we have a very important role to play with our industry stakeholders—with our clubs—to make sure we stay at the forefront of that. As Dan alluded to earlier, we are in those discussions now to ensure that whatever we have as opportunities in our business now is not eroded by irresponsible practices.

CHAIR: We will have to leave it there. Thank you, Dan and Kelly. We certainly appreciate the opportunity that we have had to hear you speak this morning and the committee once again thanks you for the great work that you do across Queensland. There was one question taken on notice, Kelly. If we could get a response by Monday, 18 October, that would be appreciated.

Mr BENNETT: Sorry, mate.

CHAIR: A little bit of homework for you by the member for Burnett. Thanks again to both of you for assisting the committee today. We certainly wish you well as we move into the end of the year, so thank you.

CHUA, Dr David, Research and Collaborations Manager, Inala Primary Care (via videoconference)

JOHNSON, Ms Tracey, Chief Executive Officer, Inala Primary Care

WILLIAMS, Dr Sue, Clinical Director and General Practitioner, Inala Primary Care (via videoconference)

CHAIR: Good morning. I now welcome representatives from Inala Primary Care. Tracey Johnson is a great colleague of mine and a fellow Churchill Fellowship recipient, so welcome, Tracey. It is really nice to have you here at parliament. Joining us by videoconference very soon with great anticipation are Dr Sue Williams and Dr David Chua. Good morning to you all and thank you for appearing before the committee today. The committee recognises, Tracey, your expertise in this area and we are certainly very excited to hear your contribution. I invite you to make a brief opening statement, after which committee members will have questions for you. Thanks again, Tracey, for your contribution.

Ms Johnson: Thank you for inviting us to come and speak before the committee this morning, with the wonders of technology as they are. Our opening address was going to be given by our research manager, Dr David Chua, but he is somewhere in the ether, so fortunately we have this wonderful thing called hard copy, which I hope is the totality of what we prepared.

Inala Primary Care is a large charitable GP practice in Brisbane's west, one of the original social housing suburbs of Brisbane. I am the CEO of that practice. Dr David Chua is our research manager and Dr Sue Williams is a longstanding GP and clinical director. Our patient cohort numbers roughly 7,000 patients, two-thirds of whom are on welfare in one of the most disadvantaged regions of Queensland. We have about 4,200 of them who are what we call very active attenders at our practice.

Our organisational purpose is to deliver high-quality primary care to all and innovative care in such a way that we can influence the way primary care is delivered across the nation by delivering relevant research and new models of care. Our research program encompasses partnerships with the University of Queensland, which is here today and will speak shortly, Griffith University and other institutions.

We implement a lot of innovative strategies because we see health care as a fundamental right and a way of capturing people's potential. We evaluate their effectiveness. For example, at the moment we are working on a frequent attender strategy. When you attend your general practice you might not think of some of the other people around you and how frequently they attend, but we as healthcare providers very much are aware of that. We have a whole strategy and a new model around those people who attend frequently as well as what we are introducing for the first time in Queensland—shared medical appointments. Rather than having a one-on-one consultation with a general practitioner, you will in fact be with a group of people who might be all newly diagnosed—and here is my lovely team on the videoconference—with a particular disease, state or condition. The research is showing that by doing things collaboratively we might get different outcomes. David and Sue, I am a third of the way through your three-minute pitch, David.

Dr Chua: Yes. Good to join you. Thanks to the committee for (inaudible).

Ms Johnson: Indeed. Maybe if I get to the bottom of the first paragraph and then you take over the paragraphs from there; how is that, David?

Dr Chua: No worries. Thanks, Tracey. I will do that.

Ms Johnson: Okay. Basically as a GP practice, being charitable, we reinvest our resources in our people—that is, we have an expansive team of 50-odd people, our research activities—and the way that we respond to the needs of our diverse community. We use interpreters in around a quarter of our consults, so we have a highly diverse and socially isolated group of people that we serve. We on average use 10 times more interpreters than any other GP practice in the country. We recognise that improving health outcomes goes beyond healthcare access, which is what we try and do by providing many of our services on a bulk-billed basis, but there is a significant social component involved in the wellbeing of the individuals that we serve. Over to you, David.

Dr Chua: Thanks Tracey. While the UQ teams represented here today are experts who know the evidence better than we do, we come at it from the general practice and primary care perspective. We do not know the true extent of social isolation and loneliness in Queensland. Vulnerable groups, particularly older people and those from a migrant background—

CHAIR: Sorry to interrupt. The connection is not altogether clear. The audio is quite bad. It might actually be of benefit to slow down a little bit. That might help us understand what you are saying a little bit better. At my end we will try to fix the connectivity issue. Thank you.

Dr Chua: I will start that paragraph again. If it gets really bad we will get Tracey to do the rest. On our end you are all perfectly fine, so perhaps it might be at the parliament's end.

While the UQ teams here are experts at the research evidence, they have better ideas or better evidence base than we do, IPC come at this from a more general perspective, from a general practice and primary care perspective or lens. We do not know the true extent of social isolation and loneliness in Queensland. It is a difficult thing to measure and what methodology would be utilised? We know that vulnerable groups, particularly older people and people of migrant backgrounds, are especially affected by social isolation and loneliness and especially women in these groups.

A paper by Professor David Ip and colleagues in 2007 studied just one immigrant group in Brisbane and identified a myriad of factors that contribute to social isolation and loneliness. That article recognised that social isolation is an overlay of cultural, linguistic and systemic factors. Many of these issues could be generalised to other groups.

There is an immensely strong evidence base linking negative physiological and psychological effects to social isolation and loneliness. These reduce life spans and reduce the quality of the years a person will enjoy. A landmark study by Professor Tegan Cruwys, who will also be represented at this committee meeting later on today, and her colleagues in 2018 found that social isolation is a predictor for frequent attendance in primary care. We also know that there is a vast evidence base that frequent attendance at primary care and general practice is paradoxically associated with poorer health outcomes. So the more someone attends general practice, generally it is an indicator of poorer health outcomes moving forward.

At IPC, 16 per cent of our patient cohort, so that is 16 per cent of 4,200 people, attend our clinic at least once a month. That is 12 times a year. Yes, many have a medically explainable reason for their high attendance, but many present with vague, unexplainable symptoms that are very real to them but are nonetheless still medically unexplainable. Increased presentations occurred throughout the health sector such as at hospitals and emergency departments and specialists. This is an inefficient and ineffective use of health care resources and we know much of this is through social isolation.

We can address this issue in innovative and creative ways. With the impending 'silver tsunami' and societal change brought about by digital transformation and the pandemic, we must act now and put in place appropriately funded programs and steps to prevent social isolation in our vulnerable populations. IPC is here today because Australian general practice has an immense reach into our communities. Ninety per cent of all Australians visit a general practice at least once a year. So naturally we welcome solutions that involve the prevention and wellbeing work that the clinics do nationally already. Thanks for having us today.

CHAIR: Thank you very much, David, and welcome to you, Dr Sue, as well. We do apologise for the technical difficulties at the start of the session. It actually helped us quite a bit when you spoke a bit more slowly. Again, it was not anything to do with your presentation; it was just the connectivity that we have in place, so my apologies. David, can you move the microphone a little bit closer to you both, which may help?

Dr Chua: It is fixed at the moment. I will see what I can do on my end.

CHAIR: We are understanding you much better though, so thank you.

Mr BENNETT: Thank you very much for your time and, again, congratulations on your submission. One of the things I would like to ask is about the recommendation for more community engagement, and you talked specifically about community hearings. I am wondering how you would see that work. Could you explain to the committee the benefits? My observations are that even the organisations are isolated and seem to struggle to find that connectivity. Would somebody like to explain that part of the submission to the committee, please?

Dr Chua: I work across several organisations. I also do some work at Griffith University. (Inaudible) we have a very interesting project that is running and Inala Primary Care has also done this in the past in the over-65 social isolation group. Community hearings involve civil societies like Queensland Community Alliance where we actually go into the communities and listen to the people. As general practitioners, as doctors and as medical professionals, we are starting to realise that we cannot put upon people interventions that we think will work even though they are evidence based.

We absolutely need to listen to the community and revolve our intervention strategies around what will work for individual model communities and neighbourhoods. What will work in Inala may not necessarily work in a place like West End or, for example, somewhere where I live.

In terms of what will work for those places, the solutions remain with the people in the community. I think listening and leveraging groups like Queensland Community Alliance and religious organisations—going in and listening to what strategies they might have—and submitting the evidence based solutions around that will certainly equal a better use of funds and better engagement.

Ms Johnson: David has highlighted that no community is the same. When you are dealing with a community like Inala, where we are serving patients from 148 ethnicities, a lot of them by virtue of their migration experience or their refugee background become very isolated. The very social fabric that we call civil society and our community can be degraded because they do not have enough other people like them. They might not have the English schools, the legal literacy, the financial literacy et cetera to set up clubs.

I am a big supporter of the work of Clubs Queensland, which appeared just before us, but in the dealings I am having with the department of sport and recreation they have identified that our community has a lower level of clubs and sporting activities and those sorts of things than any other community in Queensland. It is because there are so many pockets of people with very poor literacy and very poor activation and as a consequence it is hard for that community to form some of the social glue that might occur in other communities.

By doing this ground-up sort of work and improving the ability of the local community to hear from themselves and to equip themselves to respond to their own needs, we are going to get a much more coherent response. That is what we are calling for in that sort of local-cum-state interaction, I guess.

CHAIR: Tracey, I am well aware of some of the research that you were able to conduct on your Churchill Fellowship, particularly in relation to this issue. Can you talk about some of the learnings from your Churchill Fellowship and how you have applied that in the Inala context? What are some of the challenges or barriers that you have faced in implementing some of that well-known global research?

Ms Johnson: Absolutely. In our community 17 per cent of households do not even have a car. For them to mobilise and go places can be challenging. We have a fantastic neighbourhood centre that also runs the local legal service in our community, and I praise their work every day. When I travelled to five countries over nearly four months with my Churchill Fellowship, one of the things I was looking at was how we take the problem that we have, which is frequent attending patients who often present with a need—we try to address that. That often then triggers a response where we send them off to Queensland Health for more investigations, more specialist visits, more emergency department presentations, which is something that the state government wears a cost for. That is a common problem around the world. With Queensland Health currently costing our state budget 36 per cent of the total budget—when I was working in Queensland Health it was only 26 per cent, and that was not that long ago, so you are looking at rapidly rising costs. What I was looking to do was to find responses to bring those costs down.

I was really privileged that in America, Canada and the UK I came across what were GP embedded as well as neighbourhood centre embedded models whereby people were linking these high-need patients to local community resources. That might be a knitting group, a sporting club, a walking group—it can be a whole bunch of things that, depending upon the goals of the individual person, will get them out of the house, will give them a sense of purpose, will give them activity that will drive down some of their health presentations.

The model that I favoured the most was called the link worker model. It started in Glasgow in the United Kingdom. When I did my research there were seven link workers. By the time I got to Glasgow there were 15. By the time I did my report four months later there were 200 that the Scottish government had decided to fund. Of course, now there are thousands across all of the United Kingdom that the NHS has funded. During COVID that entire workforce, which is now incredibly well organised, well resourced and sustainably funded, has proven to be the edge that they have had to reduce mental health presentations, to improve cohesion et cetera in those communities which, of course, suffered from COVID far more than we have.

I think the lesson I learned overseas was that neighbourhood centres have an incredibly powerful role. There are certain types of people who will present to a neighbourhood centre or to a community club because they are motivated about particular aspects of their lives. However, there is

this broad group of the community—and, as David said, more than 90 per cent of the population come to general practice and they share with us things that they might not tell anyone else. We are therefore in a better position to be able to say, 'How do I "warm handover" this person because I can see that they keep coming back to me and they have sleeplessness, rising blood pressure, lack of activity—all of these things that we know are going to denude their health long term? How do I get that to change?'

Our challenge, as my wonderful team will tell you, is when you are trying to deal with somebody in 15 to 20 minutes. It is really hard to have that conversation and plan with them where they can go and find these things. A link worker is somebody a clinician can hand a patient over to in their GP practice. They then do the goal setting. They then do the individual planning about what is important to that person. If necessary, they will drive them to the relevant event. They will set up the social fabric within that community organisation to say, 'Hey, Nancy's coming this week. She needs this and that,' so that by the time Nancy arrives it is a very friendly environment. That sort of thing is incredibly important to actually take a patient from going, 'Yes, I need to exercise more,' to actually joining the walking club.

The other thing that was a global lesson across the three countries that were doing this better is that you can have a lot of expensive clinicians and link workers and those sorts of people trying to find what is happening in their local community or, frankly, you can fund an online resource to do that. In Queensland there is a wonderful group called My Community Directory that has been involved with local councils, Queensland Health and a variety of other organisations—and they are in other states as well. They are a social enterprise. They have started to map all of the things that are happening in local communities. As we well know, government provides funding for six months, 12 months, two years for certain programs and then they are over, or people start things and then they finish; you never quite know what is going on. Something like My Community Directory as a resource that is updated means that when people like my team are looking to find something unusual that a patient might have an interest in, such as restoring old cars or whatever, they can go on there and it is easy to find, whereas it can take an incredible amount of time without that sort of resource. It is cheaper to fund these things statewide than on a community-by-community basis.

Mr SKELTON: As you say, they might have to go a little bit outside the community if they have a specific interest.

Ms Johnson: Yes, but if you are passionate enough about it, because you repair old cars, you will do that.

Mr BERKMAN: We really appreciate your time this morning. There were a couple of points raised in your submission around the identified drivers of social isolation. I was really interested to see climate change in there, particularly around increases in the number of dangerous heat events and dangerous storms. There was another point around poor transport options, and it does not say it explicitly but I have assumed that that refers to poor public transport, essentially. It refers to the last-mile transport options. Is that something that you could elaborate on for us and flesh out the issue a bit more?

Dr Chua: Social isolation and transport are obviously inextricably linked. I did a quick search because some of the GPs mentioned to me that our patients had to go to Mater Hospital, for example. I said, 'That's really interesting,' because a lot of our patients can be in the Ipswich Hospital catchment. I thought, 'Let's have a quick look at how long it takes on the bus or on some sort of transport option from IPC, which is in the middle of Inala, to Mater or to Ipswich Hospital.' It is the same distance kilometres wise by road, and by car it would take roughly the same amount of time. It can take twice as long, according to the timetable, to go from Inala to Ipswich Hospital.

You can see that there are people who need to go outside the local community to engage in social activities. It is very much linked to where those activities can be placed. I am not saying that transport options in Inala are bad at all; it is just that a lot of our patient groups and a lot of the people who are experiencing social isolation, for example those who cannot speak English, cannot read timetables as well as we can. The (inaudible) actually pointed out that Chinese migrants completely avoid catching public transport that had a second connector. So if they had to change a bus, they would completely avoid it and say, 'I'll stay at home.' They much prefer to do that. That is the sort of last-mile thing. Also for people who live without a car who are maybe five minutes walk from the Inala Civic Centre, where the buses are located, that five-minute walk in the summertime heat or maybe with disability issues is very difficult. Perhaps a local, cheaper option for a subsidised pick-up service would really help them get out and lower that barrier to social care and social engagement.

Dr Williams: It is not necessarily just about public transport; it is about negotiating. If we look in regional areas where there may not be a transport system—and I have family members in South Burnett, for example—it is not that people cannot get transport; there are often informal networks that will get them to hospital. The problem is that they are so socially isolated that they cannot tap into those small networks. It is about having someone who is a networker who can say, 'Well, who do you know and who do I know in this community who might be able to help with this?' It is about that facilitation, walking alongside someone and getting them to a service, because levels of motivation can be very low.

From my perspective, I work here as a doctor and I have many elderly patients, but I am also a consumer of this, as a family member of an elderly person who is very socially isolated. It is my father. His levels (inaudible) around addressing this issue are so very low that just saying to him, 'Here's something I think you would enjoy; you just have to make your way to it,' will come out (inaudible).

The reason they are so enthusiastic about the concept of the link worker model is that it is about walking alongside those people at most need and facilitating that by helping them find their way to these events and sometimes going with them. Then we will see some improvement in their engagement. It is really about addressing the (inaudible) for people who are at most risk and most (inaudible) social isolation (inaudible).

Ms LUI: Can you explain to the committee the demographics of people who are most socially isolated? In your submission you mentioned communities that are particularly vulnerable. Could you expand on that?

Dr Chua: Certainly we were finding older persons were most at risk of being socially isolated, but during the COVID pandemic we identified that youths and younger people are becoming socially isolated because of the lockdowns and being outside of the school and university environments. They are being locked out of work and employment or training opportunities. For a younger person, school, the training environment or the workplace is the place of social connectedness, so for them it can be quite an isolating experience through the pandemic. It is something that we might have to address as a community moving forward. Definitely migrant groups and those who do not speak English is something that we have to look at because there are not (inaudible) aspects to (inaudible) facing social isolation in those groups.

I would recommend reading the paper by David Ip, who is a visiting professor at the University of Queensland. His paper captures it quite well. The reason I focus so much on that paper is because it mirrors our situation at Inala quite well. (Inaudible) in rural and regional communities and identifies where isolation in those communities can certainly be a very difficult thing. I think it is (inaudible) older persons and especially women, as I covered in my opening, people of different cultural and linguistic backgrounds and younger people. I think people like us who are (inaudible) maintain being able to come into the workplace are probably are not at the biggest risk. I think those at both ends of the spectrum are probably at the largest risk, especially women.

Ms Johnson: I will add to what David said. The other thing, if we look demographically at what has happened in all western countries over the past 30 years, is when women entered the workforce—and I am not saying we should not have had women enter the workforce in the numbers they have. Women historically played a lot of that social glue role and were actively involved in facilitating access to all sorts of community activity. Now we have women and men actively involved in putting their children in day care and working very long hours with long transportation times, particularly in metropolitan locations, to and from work. The data is increasingly showing that those young families are some of the most disengaged, particularly before their kids start sporting activities, from any form of social activity outside of their immediate household and immediate family. That is a big risk as families break down and things like that, which inevitably happens. Again, we need new strategies. We all have busy lives and busy roles. How do we engage the people who are perhaps most busy and most busy because of their caring responsibilities?

CHAIR: Sadly, Tracey, Sue and David, our time is up. We certainly greatly appreciate the insight that you are able to provide, particularly in relation to the issue of social isolation and loneliness in Inala and certainly more broadly. We thank you sincerely for your work. If the committee has any opportunity in our busy schedule to visit, we would love to do that. I have a huge favour to ask, Tracey: would you mind sending through to our secretariat your Churchill Fellowship report to ensure we capture some of the great work that you identified is happening in the western world?

Thanks again to each and every one of you. Thank you for your great work. Having been the principal of Glenala State High School for nearly six years, I understand the complexity of the community and the work that you do and the difference that you make in the lives of people who live in Inala. It is one of our most complex communities in Queensland. We do appreciate the work that you do. On behalf of the committee, thank you very much and continue that great work.

I now welcome some of the leaders in social isolation and loneliness research not just here in Queensland but certainly in the world in terms of their understanding of the issues that we are inquiring into today.

DINGLE, Associate Professor Genevieve, Associate Professor in Clinical Psychology, University of Queensland

SHARMAN, Dr Leah, Postdoctoral Research Fellow, University of Queensland

CHAIR: Thank you both for your great work. Once again, the committee acknowledges and recognises your leadership in this area. We have been greatly looking forward to hearing your contribution. We thank you immensely for being here. Without further ado, Professor Dingle, would you provide a brief opening statement? Then I am sure we will have lots of questions for you.

Prof. Dingle: Madam Chair and members of the committee, I want to start by paying my respects to the Jagera and Turrbal people and their descendants, the custodians of the land on which we are meeting today. I extend that to the member for Cook and any other First Nations people who are part of the hearing.

I did not bring a special spiel about the University of Queensland because I do not think that is particularly relevant to this. I also do not have a spiel about the neighbourhood and community centres because I know you have heard quite extensively from those organisations as well. I thought it would probably be better, because I am speaking on behalf of a research team, to really try to encapsulate the research we have been doing here in Queensland and also that we have been reading about in terms of the different efforts around the world to understand and address this problem of social isolation and loneliness. I will largely speak through my recommendations in the submission and add a little bit more detail as I go. I will also be echoing some of the great work of the earlier two groups of speakers.

Our team recommends that the solution to, and in fact the prevention of, loneliness and its driving factors is to help Queenslanders to develop meaningful group memberships. When I say that, it is because we have looked at a whole range of different approaches to loneliness. Some of them are very one-on-one, so peer-support type things and friendship things. Those are fine. They play a role. However, we really believe and there is a lot of research and theory around the fact that really it is your meaningful groups and communities that are where the action is with this problem. Based on the evidence presented in this submission and also on our readings of international research, we recommend that the best way to do this is through social prescribing to community based group activities that are tailored to that individual's specific interests and needs.

To very quickly define social prescribing for you, in a nutshell I see it as going from a traditional health kind of activity—and I am trained as a psychologist; that is my background. When you go to see a GP, a psychologist, a social worker or whatnot, the conversation opens essentially with, 'What's the matter with you? Tell us your symptoms and your problems and deficits.' It is that sort of thing and then we try to find a solution. Social prescribing is different from that because the key question is, 'What matters to you?' In fact, the answer to 'What matters to you?' is belonging. Belonging is a really key thing that can be very difficult for people to find. We have some details in here, and you have heard from previous speakers, that those things will be different for each person. It is a very multifactorial issue and it will affect different subgroups in the community in different ways.

A statewide rollout of social prescribing could be implemented efficiently and cost-effectively using existing infrastructure such as the neighbourhood and community centres network. I will add to what I have put in here by saying that I really, truly believe that we need to overlay that with the Queensland primary health networks as well—so primary health Queensland—because, as we have heard, people will find those places in their local community. Those are two very key hubs where different types of people will present.

The infrastructure would need to be accompanied by funded link worker positions—we have heard a bit about the link worker approach—and also administrative support. I know that a lot of health professionals, including myself when I was a practitioner, will say, 'It might be good for you to go and join a gym,' or 'It might be good for you to join the group that is replanting in this forest area' or whatever it is. However, it is a very difficult thing for a person to just show up, by themselves and navigate, 'Do I fit in with this crowd? How do I even get there?' There are a number of things that would need to be considered for that to be a successful engagement. The link worker plays a really critical role in this by understanding what all of those barriers are and then helping that person to remove and navigate those barriers so that they can successfully engage.

We know from the Ways to Wellness project that we have been involved in researching that it takes an average of eight separate sessions with the link worker before the person is likely to have found a group program that they really connect with and can feel supported by. From there they take off. They start to find friends and they do things outside of that group. It can roll on from there, but

there is a lot of front-end work. If you are not doing that front-end work, you may find that the person does not get through the door or does not engage well and then that further entrenches the issue: they do not want to try again because they have not had a positive experience.

Currently, link workers are not registered with the Australian Health Practitioner Regulation Authority like a lot of the other allied health and medical practitioners, unless they happen to have a background where they are trained as one of those. They do come from a diverse range of backgrounds. I do not think there is anything wrong with that. We have spoken about this in earlier meetings. We think people can come from a range of backgrounds that have really good community skills and knowledge. They may come from a teaching background; they may come from an English as a second language teaching background or a sport education background. There are a lot of different people who might play a role as link workers. What they critically need and what the clients need in terms of safeguarding and ethical oversight is really good quality training and supervision. We know from the link workers we have been working with that that is really lacking. They are very isolated themselves. Often they do not have any support and infrastructure and regular supervision and they just burn out. We have already lost a couple of our key link workers just in the few years that we have been working with this project. That is a real shame.

We think there is a real role for developing modular online statewide available resources that will give extra training to people from different backgrounds in the things they might not have had. That could be something like domestic violence of it could be something like including drug and alcohol, homelessness or what have you so that everybody has an opportunity to feel that they understand what they are looking at and how best to help that person navigate what they need.

To ensure that suitable referrals are coming in to those social prescribing services, we really need a statewide promotion campaign. We spend our time explaining 10 times a day what social prescribing is to everybody we talk to. It is just not that well understood in Australia yet in the way that it is, say, in the UK, Canada and other places. We kind of need to rely on there being a stronger understanding in the general community about what this is about, what you get out of it, how you access it and how it all works so that we are not only getting people who are the most severe and complex coming through, which is what is happening at the moment.

What you would see in a community group in Mount Gravatt Community Centre that might be around a 'crafternoon', where you are doing different arts and crafts, is fantastic, but a young man of 25 who has been out of work and out of education and who turns up to the crafternoon is going to see a bunch of middle-age, older women and feel like he does not fit there. We need to think about the different subgroups and where they are likely to feel at home so they can feel, 'There are people like me here.'

Finally, I believe as a researcher that we need to collect data on this. It is hard for us as external researchers to get access in a timely way to the individuals who are coming and going through these services. We would really like to promote the idea of a minimum dataset that is collected at the link worker as part of the routine care. That would simply be three, very quick tick-a-box questionnaires: one is about patient activation, and Tracey spoke to this—it is patients becoming much more savvy and much more self-directed in their health and wellbeing; there is a very brief three-item loneliness scale, so we want to track how that changes over time; and there is a brief symptom checklist, which is about depression, anxiety and somatic sensation. We could have that package out to every link worker and be finding out statewide what is working where and how it is working for different subgroups, different age groups, different cultural groups et cetera.

Dr Sharman: Just to add to that, it would also help link workers to figure out when a person might not need them as much. They could figure out when they are actually working for themselves and that they can start to reduce their support and help so they can go out on their own, rather than just continuing to meet them two or three times a week, or whatever it is they might be doing. I have copies of all those things.

Prof. Dingle: We have take-home packs if you like the research.

CHAIR: That would be fantastic. You would have noticed that I have been making some suggestions to the secretariat about some of the recommendations that I would like to see included in the report that we provide to government. Thank you immensely for your work.

Mr BENNETT: Chair, I suggest that the documents be tabled.

CHAIR: The suggestion is that the committee approve the distribution of the tabled documents to the committee. All in favour? The motion is passed.

Dr Sharman: I also have some other items. Would they be included?

CHAIR: Yes, that is great. The committee may not refer to them immediately but we will certainly take them with us.

Mr BENNETT: This is very exciting. As a committee, we are starting to see some solutions and some research. Our travels and our hearings have highlighted a huge number of problems in our community and I thank you for giving us a way forward. I want to understand social prescribing a bit more. Link workers exist in our community. Where would people who need their services find them?

Prof. Dingle: At the moment it is still fairly fledgling. Dr Sharman has tried to locate all of the link workers in Australia for one of our studies. She has interviewed 14 link workers. Some of them are in community and neighbourhood centres; others are part of other funding models. Dr Sharman can speak to this.

Dr Sharman: There are quite a number in community centres, and several of them are still trying to set them up in their community centres. Some of them are in primary care. In particular, there is the Primary & Community Care Services on the Gold Coast and they have a Plus Social program they have been running for a number of years. The Plus Social program is embedded into their healthcare service. They have quite a range of healthcare services. They have psychologists, GPs, nurses, social care workers and physios and they all work together. The social workers are primarily their link workers. They also have embedded within their service a number of groups which they have set up to run so they can refer them straight into the groups they have. In that way, the people feel supported by that one single service.

Primarily, link workers are referring out of their service. Some of them within community centres can refer to groups that are going on in their centres. Often those groups are not necessarily sufficient to refer out, so they will be finding and calling a lot of groups that exist nearby which people can access. They then know the other details about those groups—how much they cost, how to get there and those sorts of things—which is important to individuals.

There are not very many of them. In New South Wales they have started one relatively recently with nurse practitioners who are in GP services. They are allocating a portion of their time to doing social prescribing. Nurse practitioners are often doing that anyway, but in this way they have the spare time to be able to follow up, because the follow-up is the part that GPs cannot do. They cannot take people to services; they cannot necessarily do all of those extra things that people need them to do. There are a whole range of ways that link workers can be embedded into the community, but there are still not very many of them around.

Mr BENNETT: There is the obvious question of financing and the barriers. I am thinking of the different programs we have, like Get in the Game which encourages participation in sport. Do you see financial barriers in some of these activities? Genevieve mentioned the fact that you are trying to tailor a program to suit individuals who are all different. Is there a financial barrier that we need to be aware of as a committee?

Dr Sharman: Link workers will often negotiate finances for people to just go to the first group—so they can go and try it for free to see what it is like. Some people already have to pay for a taxi service to get there, for child care or whatever it is they need, so there are other barriers they already have to pay for. An extra $10 a week or whatever it is might not be reasonable for them and they might not be able to afford that. Having low-cost groups is really valuable, because they are highly attended and needed. A lot of people cannot afford that extra $5 or $10, whatever it might be. It is just not feasible for them.

Ms LUI: Genevieve, you mentioned in your opening statement about more training for workers. Can you share your thoughts around recruitment and if we are missing the mark in recruitment?

Prof. Dingle: At the moment there are very few jobs called 'link workers'. Mount Gravatt Ways to Wellness have advertised for a link worker, but you do not see that very often yet. We do not have recruitment, but I think before we decide to generate lots of funding for recruiting link workers we actually need the training, support and supervision structures there. I believe that in the UK model—I am closely following a lot of the global social prescribing movement—there is a National Academy for Social Prescribing. There is a link worker network, and they have regular update meetings, in-service training and that sort of thing. A lot of it has been online because of COVID, and I think that is great because it means people in all the different regions and rural areas can access that.

I believe a lot of their weekly supervision is happening through psychologists. We are very comfortable with that sort of model where everyone has peer supervision or senior mentoring on a regular basis because we are seeing a lot of mental health, trauma and those sorts of things. I do not have all the answers, but we would be very interested in being involved in the development of online training modules. That is our core business. That is one idea that we had.

Then there is a statewide weekly supervision, drop-in question-and-answer support session along the lines of what works really successfully at Insight. That is the drug and alcohol training every week, and a lot of practitioners around Australia come to that session. They are very up-to-date as a workforce because that is free for them and it is funded through ATODS and that sort of model.

Mr BERKMAN: First of all, in the spirit of giving props to local groups doing work, I should say thanks to Dr Sharman for the work you have been doing with the Inner West Social Inclusion Project with John Scoble and others. It is really nice to see that kind of active community work going on, even pre COVID.

My question goes to the fairly crude distinction between the kinds of social supports that you are talking about through neighbourhood and community centres and clinical psychology. In the persistent battle for funding, with the subsidies through mental health care plans and the doubling of the number of sessions available over the last 18 months, it is clear that the clinical psychological work gets kind of implicit favour. The funding coming from the federal government in particular is far greater than what we are seeing going to community centres. Can you give us any sense of analysis that has been done about the efficacy—not necessarily per dollar but just in some relative sense—of the funding that goes to clinical psychological support and services and community supports through neighbourhood and community centres?

Prof. Dingle: I do not think that has been done—in Australia, definitely not. There is some sort of affiliated cost analysis that has happened more along the lines of the arts and health and social care. There is the *Creative health* report from the UK that came out a couple of years ago where they have got health economists to say that if you spend £1 on someone joining a choir, being part of a dance group or whatever it will save you £11 in health care down the track. I am very interested in music and arts based health as well, and I think we have some really brilliant programs here in Queensland.

You may have heard of Upbeat Arts, which got funding through state government health, and Reclink, which is a nationwide project that I was involved in earlier. They have sport, recreation and arts based groups for disadvantaged adults. Those are excellent examples where what matters to them is belonging to a meaningful group where they are doing something, but they also have that level of support from their member organisations, which have a roster of support workers who attend. They are from the non-government sector but they are there so there is a level of support if anyone has symptoms or some issue where they need help during a session. That is a way we can look at this as social care. It is not completely separate to health; it is very much embedded in there. It is just in a different space so it is community rather than in a hospital.

Mr BERKMAN: To put a bit of a finer point on it, it strikes me—and I am wondering whether you agree—that in terms of bang for buck we are missing opportunities in funding those social supports, compared with the amount of funding that is going into clinical psychological support services at the moment.

Prof. Dingle: I absolutely do. I do not know that all of my colleagues would agree with me. One of the papers that we have just sent across to you was a systematic review we recently led which showed how much benefit on validated measures of depression, which is one of the most common mental health issues, you get from joining a meaningful group. The groups in here included sport, cultural, artistic and a range of other things. Those effect sizes were medium to large, which is exactly the same effect size I found in previous research looking at psychotherapy CBT groups for depression or in fact antidepressant medication. I feel like we have underestimated the importance and the impact of these social care options. It is not to replace anything; it is really that we need to think of them and take them seriously as a part of health.

Dr Sharman: With psychologists at the moment, we have a whole workforce that is really under stress partly because of the pandemic six-month waiting list and things like that, whereas you have these community groups that are able to fill that support gap. A lot of people are trying to see psychologists partly because they are experiencing quite significant symptoms because of being in isolation and being alone. These are actual places they could go to try to fill that gap while they wait or try to improve their symptoms as well.

Prof. Dingle: We need clients to understand that, as well as all the other people in the health system; otherwise they can feel fobbed off. They can come in and say, 'I'm really not well, and you've told me to go and join the knitting group.' If they do not understand the whole nature of it and how it can help them, I think that can be a mixed message. The messaging and the infrastructure have to be there, too.

CHAIR: We are sadly out of time. I wish we had many more hours with you to try to get inside your brains and delve into some of the further research you have done. It was remiss of me not to declare my professional association with Associate Professor Dingle at the outset of this hearing. I do declare my association there and the work that Professor Dingle and I have done at the Mount Gravatt Community Centre in relation to the social prescribing model. The committee really appreciates the support of the University of Queensland, and you may be aware that three of your fellow colleagues are visiting us later today. We cannot do our work without your research and clinical evidence to support the spending of government funds. We certainly appreciate the ongoing support you have provided to our committee.

You have provided our committee with your research. If you do further research in the coming months we would love to receive a copy, if that is okay. The committee thanks you for the great partnership you have with us. We look forward to working with you and sharing with you some of the findings of the committee and how we might navigate some of the implementations that we suggest. I thank you again. I am sure our work will continue together.

Prof. Dingle: Thank you so much for putting this on the agenda. It is so great to see this happening in Queensland, so thank you from us as well.

Proceedings suspended from 11.02 am to 11.29 am.

CULLEN, Ms Jade, Social Worker Advanced, The Prince Charles Hospital, and Social Work Professional Leaders, Metro North Mental Health, Metro North Hospital and Health Service

PALMER, Ms Ali, Social Work Professional Lead, Redcliffe/Caboolture, and Social Work Professional Leaders, Metro North Mental Health, Metro North Hospital and Health Service

UZABEAGA, Ms Carissa, Social Work Professional Lead, The Prince Charles Hospital, and Social Work Professional Leaders, Metro North Mental Health, Metro North Hospital and Health Service

CHAIR: Welcome. It is wonderful to have you here this morning. Thank you for the work you have done to date to contribute to our inquiry into social isolation and loneliness in Queensland. Thank you for the contribution you make to health in Queensland. We ask that you take this time to make a brief opening statement and then I am sure our committee members will have lots of questions for you.

Ms Uzabeaga: Metro North Health respectfully acknowledges the traditional owners of the land on which our services are located. We pay our respects to elders past, present and future and acknowledge Aboriginal and Torres Strait Islander people across the state. Metro North Mental Health recognises the lived experience of people living with mental illness, problematic alcohol and other drug use as well as those impacted by suicide and trauma, their families, carers and support people. We respect and value their opinions and their input into service delivery and change.

Good morning, members. We begin by thanking you for the opportunity to make a submission here today and for inviting us to speak. We are excited to be a part of this opportunity to explore issues of social isolation and loneliness within Queensland. We are here today representing the social work professional leaders within Metro North Mental Health. I also recognise and acknowledge the contribution and insights of Kim Sander, who is unfortunately not able to attend today.

To provide some background and context to our submission, I will firstly provide an overview of the service we represent. Metro North Mental Health provides tertiary mental health and alcohol and drug treatment services within Metro North Health. Metro North Mental Health services are across five public hospitals, including Royal Brisbane and Women's Hospital, Prince Charles Hospital, Caboolture Hospital, Redcliffe Hospital and Kilcoy Hospital. Within all these facilities there are 340 mental health inpatient, community and residential beds that span the age spectrum, including perinatal, child and adolescent, and adult and older persons. Furthermore, we have a number of community and specialist services for child and adult mental health, forensic mental health, alcohol and drug treatment, eating disorders and homelessness.

Our model of care applies the mental health recovery framework trauma informed care principles and delivers services in partnership with consumers and carers and in collaboration with primary and private health and our non-government partners. Metro North Mental Health is also a host site for a range of services provided to the statewide catchment for both mental health and alcohol and drug services.

The social work profession within Metro North Mental Health comprises approximately 100 dedicated clinicians who are located within all areas within the mental health and alcohol and drug treatment settings. Social workers are committed to providing care and treatment to clients with severe and complex mental illness and alcohol and drug dependence and their carers. Social workers operate at the interface between people and their society, their culture and their physical environments, and in all contexts social workers maintain a dual focus on assisting human functioning and identifying the system issues that create inequality and injustice.

We have followed and reviewed the many submissions presented to the inquiry so far and note from the general themes that social isolation and loneliness within Queensland is indeed an issue of rising concern and that the solutions need to be multifaceted and diverse in acknowledgement of the complexities associated with this issue. As such, the social work professional leaders recognise that Metro North Mental Health is just one part of the system where there is an opportunity to address the issue of social isolation and loneliness.

The focus of our submission is to highlight the needs of mental health and substance dependent clients of Metro North Mental Health who are further marginalised and impacted by the issues of social isolation and loneliness, emphasised by the COVID-19 context. Ideally, we would like

to see additional resources for tertiary mental services to further develop and sustain new and innovative treatment interventions being offered by our services which assist our clients to engage in meaningful and purposeful social connections. Also, additional resources would assist to formally research the treatments to confirm the impact of improved social connectedness on morbidity and mortality rates within this marginalised cohort as well as contribute to the body of evidence regarding effective solutions for social isolation and loneliness.

Ms Palmer: As outlined in our submission, Metro North Mental Health has seen an overall nine per cent growth in mental health coded presentations within our emergency departments since the beginning of the pandemic and a 41 per cent increase in help-seeking callers to ADIS, the alcohol and drug phone line. We have seen this trend in presentations continue into 2021, demonstrating the impact that isolation, lockdowns and physical distancing have on our service demand in both emergency and community health settings. These increases in demand impact on resource allocations and away from the development of new and innovative treatment interventions.

In the tertiary mental health setting we provide treatment and care to consumers with severe, complex and enduring mental health and substance use dependence. The model of care has traditionally been that of generalist individual case management, and this continues to be the predominant model to the present day. In this model of care the emphasis is on the individual to be the agent of change, with the focus of interventions on the biological and psychological aspects of the person's presentation. This, however, places responsibility predominantly on the individual to change to improve health. The model offers only limited focus on social needs with prescribed support or routine community referrals. This is just one of the barriers identified that limits social connections for our cohort. Others include our consumers' capacity to navigate the many complex systems that they interface with across the government, non-government and private sectors, along with their general capacity and decision-making challenges. They face barriers to accessing neighbourhood and community services due to the severity and complexity of the challenges they experience. There are difficulties in these services meeting the needs of these clients due to the level of skills and experience of staff in these settings. Mental health and alcohol and drug clients have additional challenges in relation to social connections due to stigma, poverty, homelessness, trauma, family and support network breakdowns, transportation, digital exclusion and social and communication skills, along with other associated health comorbidities.

Social workers within Metro North Mental Health have developed a level of expertise and knowledge in mental health and drug and alcohol treatment. The Australian Association of Social Workers classes mental health social workers as an advanced practice. We believe that our social workers are in a unique position, time and resources permitting, to embed interventions for our consumers to improve skills in social connectedness as well as to advocate for and build capacity with the community to engage this cohort in mainstream isolation and loneliness initiatives and thus transition consumers from reliance on public mental health services to self-efficacy within an accepting community.

The social work leaders at Metro North Mental Health look forward to working alongside our non-government and government partners in developing and embedding social connectedness interventions into the tertiary mental health setting to improve outcomes for our mental health consumers. We welcome opportunities to engage in research in this area and develop a community capacity building model that supports our consumers to engage in positive social connections for overall improved health outcomes. We also acknowledge the vital role that consumers and carers can play in co-designing solutions with us. Thank you for this opportunity. We welcome your questions.

CHAIR: Thanks for that very thorough introduction.

Mr BENNETT: That was very interesting. I believe that you were here before when the professors were talking about social prescribing. Am I correct in saying that you would see social workers and link workers having a similar role in embedding into places outside tertiary organisations—places like community centres? I am not trying to put you on the spot. I will ask it a different way. Do you see that prescribing other activities for your clients would be beneficial in dealing with their mental health?

Ms Palmer: We definitely support the social prescribing model and think it is excellent. We really appreciate the work that Professor Dingle has done. We see that there is a whole body of work that we need to do in a tertiary space to get our consumers ready to engage in that. There is also an opportunity for us to work with the community workers to help them to be able to manage our cohort.

Mr BENNETT: Would you say you would need probably eight contact sessions with your clients before you would even get them close to being ready? I guess everyone is different.

Ms Uzabeaga: I think mental health and alcohol and drug treatment is individualised and it depends on the level of social deficits that our consumers present with. A lot of the work that we are already doing in this space is around trying to build their capacity to engage in mainstream services such as those being provided by the neighbourhood centres and community centres. However, we are doing that on a much more individual basis. We are looking at different ways to try to touch more people in a more efficient way.

Mr SKELTON: You note that the people suffering severe mental health and substance addiction present differently to others who might be impacted by social isolation and loneliness. The deputy chair was alluding to the fact that there needs to be different measures for different people. Can it be embedded in the community setting, bearing in mind that there are extra challenges for those people?

Ms Uzabeaga: We work very closely with our community partners. Obviously we recognise that tertiary mental health services are not able to do all of the work that needs to be done. We are often a starting point. We work closely to refer our consumers into those community services that can do that ongoing work and try to provide more of that intensive work out in a community centre. I see it as a partnership. I see it as something we need to do alongside each other. It needs to be a parallel process where we are doing things in the tertiary space and they are doing things in the community and we can interact.

Mr BERKMAN: I want to go a little further in terms of the question that the deputy chair put to you. You mentioned in your opening statement or perhaps in response to his question that there is a lot of work to do with folks who are getting care in a tertiary setting to get them ready for social prescribing. What does that look like? What sort of work supports or progress needs to be made before social prescribing might be a worthwhile pursuit with these folks?

Ms Uzabeaga: I think we are engaging in the social prescribing idea. I do not think that is not something we are already doing. We are engaging our community partners to support consumers to make those social connections in the community. What we identifying more is that the consumers who access our services are usually at the severe and complex end. They often have quite enduring mental illnesses and have quite a distinct deficit in terms of social interactions. They really struggle to identify social cues and challenge their thoughts and beliefs around what might be presented in front of them. For us it is about trying to support them to engage and role-model that engagement into social situations and try to help them to feel comfortable in that space. There is often a lot of stigma attached to mental health and drug and alcohol consumers. We are continuing to try to break down those barriers for our consumers accessing those sorts of mainstream services.

Ms Palmer: There is a lot of work on therapeutic interventions around emotional regulation and social skills building as well.

Mr BERKMAN: Maybe I did not frame this very well in the question. It is much more about doing more work with the individual health consumers in that setting so that they are in better position to engage with social prescribing.

Ms Palmer: Yes, and then at the same time us working really closely with all the stakeholders to understand how to support and best manage people who present with risky or complex behaviours as well. We do not want to set anyone up for failure—that is, go out into the group and then it all turn bad.

Mr BERKMAN: I am interested in the particular vulnerabilities of people struggling with substance abuse. We have not heard a great deal about that cohort as a particularly at-risk group in the context of social isolation and loneliness. Is that something you can elaborate on for us a little?

Ms Uzabeaga: We would see mental health and alcohol and drug consumers as already a vulnerable group. They have certainly been exacerbated by the COVID-19 pandemic. Mental health consumers and alcohol and drug consumers often are quite isolated from their families. Their families have often separated themselves away from our consumers, so we do notice that they are generally a population group that does not have a lot of great prosocial relationships. They are often quite vulnerable in just the general context of being taken advantage of and have a lot of challenges then in really actually finding friends and social supports who are actually there to support them in their best interests.

Often those prosocial connections are made by community organisations or public mental health services, so by service providers and support workers and things like that who are often more in that professional kind of context and not so much in that social context. They often socialise in groups with their own peers which then exacerbates that vulnerability, and I think that demonstrates that they are often put in situations that then increase their vulnerability.

With the COVID-19 pandemic we have seen services having to change their service models so they are not providing as much outreach or they are not able to sustain the supports they had previously been providing due to social distancing, lockdowns and things like that. We have either moved to digital means of interacting or just clients actually isolating at home and so not then getting that engagement and that outreach that they need. We have seen that the COVID-19 pandemic has exacerbated them then as a vulnerable population group.

Ms LUI: We heard from a different organisation around mental health a couple of weeks ago stating the difference between mental health services sitting in the health space and those sitting outside of the health space. I think one of the points that was highlighted was the barriers around referral and getting clients through the system. What are your views on the referral process and if it is working effectively?

Ms Uzabeaga: Do you mean a referral into public health mental services or referrals out to community services?

Ms LUI: Into, yes.

Ms Uzabeaga: Professor Allan commented in his submission that there has been about a 10 per cent increase in presentations across the state. That has certainly meant that we have had to manage that increase within the resources we already have. I do think that will then increase the bar of the referrals into. However, I do know that our acute care services are working really hard to make sure they see whoever does need to be seen and do their very best to accommodate those referrals. I do not believe there are any barriers in referrals in to accessing that at least assessment phase, but there is certainly, we have seen, an increase in presentations which has certainly put some pressure within our systems.

Mr BENNETT: In your professional training for social workers—not so much where they are being trained—has the training model changed to start to include things like social isolation in the work that you need for your professional capacity to be operating?

Ms Palmer: I think very much so our training is definitely around social inclusion, relationships and interactions with all the different systems that people are accessing. That is our core background.

Mr BENNETT: If someone new is recruited now, would they have more exposure to that changing dynamic or has this issue been around, in your opinion, for longer than we have probably known?

Ms Palmer: It is probably embedded more into our profession.

Mr BENNETT: Are there plenty of people to recruit from? Is there a pool that is doing the training?

Ms Palmer: There are many universities offering social work degrees.

Mr BENNETT: We are not burning them out too much, I hope.

Mr BERKMAN: I will go back, if I might, to the question of dual diagnosis. Is there a particular focal point for better addressing dual diagnosis before we see folks ending up in a tertiary healthcare setting? We have heard a little bit from one of the neighbourhood and community centres—Momentum Mental Health. They have taken that on as a particular focus. They are dealing more specifically with all sorts of mental health issues, but dual diagnosis was one thing they identified as being particularly difficult for them as a neighbourhood and community centre to deal with. From the social services right through the primary health network, how could we best be addressing dual diagnosis ahead of arriving in tertiary healthcare settings? There is a little can of worms there.

Ms Palmer: It is probably a question more for our executive in the drug and alcohol service, actually.

Ms Uzabeaga: We have had a no-wrong-door policy in mental health and alcohol and drug for a long time. I believe there are some new dual diagnosis guidelines that are in progress at the moment. There is certainly lots of work going into that space to try to make sure we are not missing anybody and we are offering as many opportunities as possible for people to engage in help-seeking behaviours.

Ms LUI: Your submission talks about an increase in the number of young people with mental health presentations since the COVID pandemic. I guess the assumption is that young people are better connected, given their age and their connections via social media or technology. Would you be able to make some comment on the increase?

Ms Uzabeaga: We certainly have seen an increase. As you can see from the submission, it was quite a significant increase, keeping in mind that that was just in the context of that 10 per cent increase that we talked about. The COVID-19 pandemic is certainly affecting children and young people. It is certainly something the service is working to look at: how we might be able to improve those outcomes. We have an early psychosis program that works with consumers from 18 to 25, and certainly that early psychosis program has been doing a lot of work. They run a social connection program with their young people and are really trying to build those prosocial connections for them to assist them so that they are not having this long-term journey through mental health services. That has been working very effectively in the service.

Ms LUI: To try to get some clarity around why there is an increase—I think someone mentioned lockdowns—what are your thoughts around the specific challenges for young people such that we are now seeing an increase in presentations?

Ms Palmer: I am not sure that we can comment on that. I think Professor John Allan might have commented a bit more about that in his submission.

Mr BENNETT: In acknowledging we should not be asking you for opinions, if I can go back to where we need to be—people presenting as clients—where in the conversations do we try to park social isolation and loneliness in the mix? It is a complex area and I am not asking for a medical term, but is it part of the first engagement with your clients that that becomes part of your assessment?

Ms Palmer: Something all mental health clinicians routinely do when we are meeting with people is a thorough assessment and develop what is called a clinical formulation. That identifies what have been the triggers for this person coming, what are the vulnerabilities, what factors are maintaining it—that would cover those sorts of issues as well—and what are the protective factors. We would routinely look at that when people are coming in to see us.

Mr BENNETT: One of the common things we have heard is about finding suitable, safe accommodation solutions for people. Are we seeing the disconnect for your colleagues in regional and rural areas about finding somewhere—you cannot keep them onsite forever, I guess—and they are going to need to transition to health and wellbeing? Do you have the respite capacity in metro? Is it called respite or is it emergency accommodation?

Ms Palmer: Homelessness is a huge issue.

Ms Uzabeaga: We have identified homelessness as a major concern for us. Part of my role involves the acute inpatients at the Prince Charles. One of the biggest challenges at the moment is around finding appropriate and suitable accommodation for our consumers. A lot of the crisis accommodation providers that we have previously been accessing here in metropolitan areas have unfortunately suffered from the COVID-19 pandemic due to social distancing and things like that in terms of what they are allowed to actually offer, so it has really impacted significantly on us being able to source emergency accommodation for our consumers.

Ms Palmer: There is a body of work done in maintaining current housing as well for people when they become well. We put a lot of work into trying to stabilise them.

Mr BENNETT: Do you call it crisis accommodation or do you call it something different—for the committee's benefit, if we had to put a label on what you are looking for?

Ms Uzabeaga: Crisis/emergency accommodation.

Ms Palmer: And affordable housing.

CHAIR: If we were to think about the issue of social isolation and loneliness in Queensland, what would be three things that you would recommend our committee recommend to the government?

Ms Uzabeaga: In terms of the things we have considered as part of thinking about the submission and looking at what we are actually presenting here today, certainly we would like to see that tertiary mental health services have an opportunity to play a part in this. We acknowledge that we are just one part of that very big system that works together to address social isolation and loneliness and so would really like to see that there may be something we can do in that space to assist with our consumers. We certainly want to promote and advocate for the mental health and alcohol and drug clients because we definitely see them as a very impacted and vulnerable group when it comes to social isolation and loneliness, both generally and then exacerbated by COVID-19.

Ms Palmer: Those are two big things. Both of those obviously have resourcing implications.

Ms Uzabeaga: The other thing we had discussed is around an infrastructure or some way to actually develop capacity building for our consumers. They cannot just walk into mainstream social groups and interact socially; they need that step before of being able to learn the skills they are going

to need to socialise appropriately. One of the biggest things we do within our context is around helping to role-model and develop those prosocial behaviours so they can actually walk out of our services and into social groups successfully.

Ms Palmer: Social workers having social connectedness embedded into our health policies, frameworks and models of care would definitely bring it onto the agenda a lot more.

CHAIR: You would argue that we do not have that currently for social workers across Queensland with the government?

Ms Palmer: Probably not as explicitly as it could be.

CHAIR: That is good feedback. There being no further questions—time is of the essence of course, as always—the committee thanks you for your submission and for the great work you do every day to support our constituents in the north of Brisbane in particular. Thanks again for your professionalism and certainly your insights into this very complex issue.

CRUWYS, Associate Professor Tegan, Associate Professor and Clinical Psychologist, Australian National University (via videoconference)

HASLAM, Professor Catherine, Professor of Clinical Psychology, University of Queensland

HASLAM, Professor S Alexander, Professor of Social and Organisational Psychology, University of Queensland

JETTEN, Professor Jolanda, Professor of Social Psychology, University of Queensland (via videoconference)

CHAIR: I now welcome representatives from the University of Queensland. It is lovely to have you here today. The committee feel very fortunate to have the insights and the research of the University of Queensland. Thanks again for the academic perspectives that you will provide for us. We are also joined by videoconference by Professor Jolanda Jetten from the University of Queensland and Associate Professor Tegan Cruwys from the Australian National University. Good afternoon to all of you. We look forward to hearing your insights. We ask that you make an opening statement, perhaps from the University of Queensland first and then from Associate Professor Tegan from the Australian National University. Then I am sure our members will have questions for you.

Prof. C Haslam: We did want to thank you also for the opportunity to present here and be witnesses to the hearing. I am going to be summarising our submission to the inquiry, trying to kind of contextualise it for you in the few minutes we have. I do not know whether Tegan would like to follow up on that, but I am speaking on behalf of us all.

Our submission to this inquiry actually drew on data we had from the Australia Talks survey but also some of the research that we conducted in the first wave of the pandemic last year. There are three key points that we really want to get across in the submission. First, the data actually showed that about 15 per cent of Queenslanders reported frequently or always feeling lonely. Those figures are pretty comparable across the states and territories in Australia. In the first wave of the pandemic—that was between March and June last year, when we were collecting this data—there were small increases that we saw in social isolation and loneliness across the nation. These were greatest in two groups: those aged 17 to 25 years and those aged 35 to 50 years.

Second, we identified two key drivers of loneliness from the Australia Talks data: a general decline in social participation and membership of organisations, clubs and societies—and, again, this decline was greatest in young people. A second driver was disadvantage and economic insecurity. These are important because they reduce not only your access to resources like safe housing, safe living environments and healthy food but also opportunities to maintain active, socially connected lives.

Finally, we highlighted two key solutions to the problem that we feel can be embedded in our community. The first is seen in social prescribing initiatives that are supported in large part by the voluntary sector and also the charity sector. You heard about this in the previous submission but also from our colleague Genevieve Dingle, who spoke earlier today. The evidence from these interventions is growing and I think they are well placed to contribute to community based solutions. However, we still do need some more rigorous evaluation to ensure systematic measurement of their outcomes and also whether these are sustainable in the longer term.

In terms of our second recommendation, we think we can be more effective if alongside social prescribing we empower people to stave off loneliness by helping them to independently manage their social connections and networks. This is something that is addressed in a new program that we have developed at the University of Queensland. This program, Groups 4 Health, gives people the knowledge and the skills to manage their social group connections and their community networks in ways that support their health. We have conducted three phases of clinical trials with this program that have been published in leading journals. These confirm that Groups 4 Health is effective in increasing social connectedness, reducing loneliness, reducing depression and reducing social anxiety. Particularly important in the COVID context, our most recent trial showed that Groups 4 Health was more effective than the gold standard treatment of cognitive behaviour therapy in protecting people against loneliness relapse during the COVID restrictions, when social connectedness was really threatened. As we see it, a phase 4 trial that looks to deliver Groups 4 Health at scale is the obvious next step.

To sum up, loneliness is a very serious problem in our community, particularly for young people and those facing disadvantage and vulnerability. If we invest in social prescribing and Groups 4 Health, we feel we will have the wherewithal to prevent and manage this problem of loneliness much better than we do now.

Mr BENNETT: Well said.

CHAIR: I concur with the deputy chair: well said and well presented, Professor Haslam. Are there any other comments in relation to an opening statement from your colleagues?

Prof. Cruwys: I would say that Cath has done an excellent job of summarising on our behalf. There is maybe one other point I would emphasise out of our research—that is, the link between loneliness and health is extremely robust in the science. This is not new science; this is work that has been coming out time and time again over the last 40 years. To say that it is a strong predictor of health is almost understating it. In fact, the meta-analytical evidence would tend to suggest that loneliness is a stronger predictor of community health than things like physical inactivity or obesity. It is on a par with things like smoking. I think it is a bit of a travesty that the science has been so strong in showing this link for decades and yet we have made so little progress when it comes to actually doing something about it. We take action on other key predictors of health as a society, which is great, but we are really lagging behind in terms of solutions for loneliness. I think the summary that Cath has given and some of those emerging solutions are great, but there has generally been much less investment in loneliness compared to other predictors of health.

CHAIR: Our committee absolutely agrees with you, hence the reason we are here today to talk about what can be done to address this very significant health issue.

Mr BENNETT: I have two areas I want to investigate. You mentioned 15 per cent of people in the survey and the data who identify as being lonely. Is it fair to say that some of those people can cope quite satisfactorily with being lonely and in some cases elect to live a solitary type of life? Am I just generalising?

Prof. C Haslam: I would say that you are right: there are some people who actually seek solitary lives. These are the people who do not experience loneliness. These are the people who choose to seek isolation, to engage in high-level thought, to engage in particular levels of work that they need to do. We all do that at some level, I think.

The people who are really experiencing significant loneliness, that pain associated with your relationships not being the way you would want them to be—these are the people who are experiencing the mental health problems that the earlier group of social workers were talking to you about. This 15 per cent are not sometimes feeling lonely; this is at the upper end. These are people who are reporting frequently and almost always feeling lonely. These are the people who are really suffering.

Mr BENNETT: Today has been a light bulb moment with some solutions that have been talked about in terms of social prescribing. Could you give us a quick overview of the Groups 4 Health program, some of the examples that the committee might benefit from hearing about?

Prof. C Haslam: Our program is quite different to a lot of other programs. A lot of programs that already exist are talking about one-on-one connections and trying to build those and build people's confidence in having those connections. Our Groups 4 Health program focuses very much on group belonging. We are a group of researchers who look at the impact that group connectedness has in positive and negative ways on people's health and wellbeing. This program focuses very much on that. It really hones in on trying to help people to connect with their family and friendship groups, their work and professional groups, their community and interest groups. What we do know is that those group connections, when they are a positive source of influence across a range of different health conditions and contexts, have really positive health outcomes.

The program itself—our in-person version, our original version—has five sessions. These sessions aim to provide people with a little bit of education to begin with—psycho education—to understand what groups are, which groups are helpful and which groups are harmful for our health. Our second session actually aims to raise people's awareness about which groups are in their lives currently, how they relate to those groups, which are working well for them and which are not. We use all of that information for the next two sessions. The focus very much is on making the most of your existing connections and trying to harness those that are especially beneficial for health, helping people to identify these which are the ones to really invest in.

Our fourth session focuses very much on helping people to build positive new connections and using the Groups 4 Health group, which is new for everybody who takes part, as a platform from which to try to build those skills and try out some of those strategies that we have been developing with them.

Over the next month after that, as part of that fourth session, we aim to help people to build social plans in which to strengthen existing connections and to extend their connections. We provide an opportunity for people to trial that. At our final session, when people come back a month later, we troubleshoot challenges, celebrate wins but also revisit their original what we refer to as social identity maps—these are a visual illustration of people's social group worlds—to see how these have actually been modified or changed in the context of people actually being in the program.

I alluded to the fact that we have a number of adaptations. Our five-session program has been developed specifically for people who have vulnerability: loneliness and isolation in association with mental health problems. They are our target sample there. We also have adaptations of the program for people who are transitioning to university study, which is Groups 4 Education, where we know that people are also experiencing social isolation and mental health problems. We also have Groups 4 Health: Retirement and Groups 4 Health: Sport because of the data showing us that that transition out of the workforce, that life change, is also associated with increased mental health problems and also mortality risks, and we know about the data in terms of leaving elite sport. These are adaptations of the program that exist and that we are actually collecting data on as well.

CHAIR: They were two really great questions from you, Deputy Chair. Professor Haslam, I am interested in your focus on existing groups. I know from the work that we are doing with the Ways to Wellness program in Mount Gravatt that often there are not existing groups. I really acknowledge the sensibility of connecting with existing groups and exploring those existing groups to the full extent because obviously that is going to be far easier than creating new groups. Could you talk to us a little bit about the participants or the clients of the existing groups versus those members of our communities that we represent who do not have existing groups?

Prof. C Haslam: That was the very reason we have two aspects of the program, about making the most of existing connections but also about building new ones. You might find yourself in a situation where you have been disconnected for quite some time. As a result of that, you do not have a base from which to work. We work on both of those pathways and we give people the opportunity to focus on which of those pathways—or both pathways, depending on what it is—is going to be best meeting their needs. That is what our research also shows: continuity of groups is really important, but also extending and developing new groups is really important.

For those who are not well connected, we will be working with them to try to help and identify ways that they can connect with groups that will make a meaningful and purposeful contribution to their lives because those are the groups that stand the test of time. Those are the connections that people will hold onto. That is part and parcel of what the program actually does.

It is interesting: when people come to our program, it is not one or the other that people are seeking. Some people will come saying, 'I have enough group connections. I just want to make more of the ones I have.' Others will come, as you say, because they have no connections and they want to be able to start developing those networks and extending on that. The program provides a really good opportunity to target what a person needs in those contexts.

Prof. A Haslam: I will add that one of the features is delivered in a group context. You have a cohort of people going through the program, so they are a little crucible and work together, if you like, and work through their problems and issues together and recognise that these things are not just things they are experiencing on their own but they are shared with other people. They then develop solutions in collaboration with those other people and in some cases go out into the world with those other people, but they have a resource. The program itself is building one new group, which is the Groups 4 Health group, and that is, if you like, the place where you can experiment in a safe space and address these underlying issues of things like social anxiety, apprehension and trepidation about entering into the wider world.

The other thing I would say is that there is plenty of evidence through work we are doing with the Royal College of Psychiatrists in the UK that this emphasis or this shift is part of a general shift to address these issues, or a desire to address them upstream rather than downstream. We want to build people's social connectivity before it becomes a problem. Cath was talking about the Groups 4 Health: Retirement program. That is something every single Queenslander could benefit from, not just people who are suffering from loneliness, depression or anxiety, because we all need to be reminded of the importance of social groups. Your research and our research shows that that is a much better predictor of happiness, wellbeing and health in retirement than, for example, your financial status, but far more money goes into people preparing their financial plan for retirement than their social plan. That is set to have devastating consequences unless we take a systemic pathway to addressing it.

Again, I just underline the point that Cath and Tegan made, which is really welcomed, around the fact that you are putting this issue on the agenda and raising its profile. I think it is something that needs to be seen absolutely not as a kind of niche topic but as something that is central, that is a broad suite, a catalogue, a litany, if you like, of health issues which we as a society really need to have a joined-up way of addressing.

CHAIR: What occurred to me then, Professor Haslam, is the potential for multimillion dollar superannuation companies to perhaps broaden the spectrum of their roles and how they might contribute to some ethical engagements with preparing people for retirement.

Mr BERKMAN: Associate Professor Cruwys, in your opening statement you honed in on how well established the links between loneliness and health are, but I feel like we as people generally do not intuitively understand that link between mental health and physical health. Is there any way you can put in a nutshell for us what that link looks like? Are we talking about clearly established physiological links between mental health processes and physical health? Sorry, it is probably not a small question at all, but is there a natural response?

Prof. Cruwys: It is an excellent question but a tricky one to answer. We have growing insight into the how and the why. I would say the strongest evidence we have is that it does exist. It is over time, so people who become lonely are at an increased risk. It does not go the other way around as strongly—that people who have developed poor health subsequently become lonely. That relationship does exist but it is not as strong. More recent evidence is starting to understand the mechanism. There are some physiological mechanisms to do with an immunological response to stress and that the body responds to social isolation as an acute stressor, but when we have that stress response in the body over a long time, that chronic stress response does physiological damage and has an inflammatory response.

There are also psychological resources that come from our social connections that are particularly beneficial for our health and those effects are quite strong on our mental health. Our team has definitely done some research that has shown that when people are part of groups, when they are embedded in communities and have that sense of belonging, there are all kinds of resources that flow from that. Some of it is really concrete—like when you need to borrow some money or move house there is someone who can step up and help you. Then some of it is less tangible: it is emotional support, it is a sense of purpose and it is a sense of agency that you can get things done when you need to get them done. All those psychological resources contribute to your mental health as well.

Mr BERKMAN: Wonderful, thank you. Professor Haslam, in your opening statement you referred to the need for a more systematic measurement of the outcomes of social prescribing. Not necessarily social prescribing, but we have heard from neighbourhood and community centres about how they are endeavouring to take a data driven approach to the outcomes they are achieving. Would you suggest, though, that there is a parallel need to really interrogate in a more systematic way the outcomes of conventional clinical psychological support? I have asked questions along these lines before and it sounds like there is not any kind of comparative analysis being done, but, while we are funding mental health care plans for folks at pretty extraordinary levels compared with neighbourhood and community centres, how do we make that comparison and where are the most opportunities?

Prof. C Haslam: I think it is a good question to point out. We do collect that data in the health service. The challenge for us is that that data actually is not being collected in the community services as well, particularly if they are not being supported by health services. Particularly with the social prescribing initiatives, charities and NGOs have been saying for years, not only here but also in the US and the UK—they have been doing this stuff for years, and they have. There have been a lot of different initiatives that have been put in place; they just have not been measuring their outcomes.

You will be hearing a little bit later today, I understand, from Michelle Lim and Jo Badcock from Ending Loneliness Together. As part of that network, Jo has led on trying to help community organisations and charities to do that measurement, to undertake what is a simple way of assessing loneliness outcomes. I think they will be talking to you a little bit more about that later today. We need to do that comparison. You cannot do the comparison until you actually have the data, and I think we will need to have that comparison going.

I think the UK is ahead of the game on this one. They are already starting to measure, and I think we can look to some of the data from the UK because some of their loneliness statistics are very similar to ours. It is not that there is anything unique about Australia in some of the things we have been experiencing here. I think with the data we can actually do some work on that to understand how these are making a contribution.

I would be particularly interested in having a look at prevention because, in a sense, what you want to do is reduce the burden on the health service if you work earlier and if you work within those communities. Information about whether these social prescribing initiatives have an impact on significantly reducing the health burden that comes into A&E and other services and GP surgeries would be really useful for us.

Prof. A Haslam: In the submission you made the point that the next phase of clinical trial for Groups 4 Health would be a much bigger rollout, and as part of the proposal we developed we submitted a bid to the MRFF scheme. Unsurprisingly, because most of the funding on that scheme goes to classic biological medicine stuff, we did not get that funded, but part of that was indeed to have a full economic analysis of the benefits—what you are getting as a return on the dollar.

One thing I alluded to is that all of this work is summarised in this book that the four of us and Gen Dingle published two years ago, *The New Psychology of Health: Unlocking the Social Cure*. One of the studies we compared was that if you invest a dollar in diabetes research you get something like a $2 return. If you invest a dollar in a community association you get something like a $4.30 return. You are not actually comparing like with like because those studies that you talk about, which absolutely need to be done, have not been done. More particularly, nobody has ever invested in doing them. I think in this space a lot of people want to have one-horse races. Unfortunately, most of those people come from the medical side of the community rather than, if you like, the social community side.

CHAIR: The difficulty is always measuring the effective domain. The work of community centres, the work of addressing social isolation and loneliness, is not easy in terms of measuring its impact. What advice do you have for the government around how we might measure impacts from organisations and community centres who are doing different things, who are dealing with different individuals with different issues—it is a complex context to try and measure—to ensure validity and reliability?

Prof. C Haslam: The Ending Loneliness Together group have developed a guide for charities, organisations and community organisations, drawing on the evidence base, and they have a measure of loneliness that they are recommending to measure this systematically, which is exactly the point that you are making. There are too many different measures that are out there in the community. We need to recommend the evidence based loneliness measure—something brief that will not be too invasive. What they have recommended is a one-item and a four-item measure, based on the research they have been drawing on about which are the best loneliness measures that can be applied in that community sector. Then it basically will be up to policy to promote this and push this as a way of collecting that data.

You are right: there is a range of other outcomes which are important to measure. I think the jury is still out on that one in terms of what are the best things to actually measure, and that might change or modify service by service, depending on what the service is trying to achieve. I think some more work in that area in terms of looking at some wider outcomes, not just loneliness outcomes, could be pretty useful for us, too.

Mr SKELTON: I was very interested in part of the survey that you conducted saying that there is an actual drop in the participation rate of younger people in community groups, sporting groups and clubs et cetera, and that is just over that two-year period. Do you know what are the drivers of that?

Prof. A Haslam: The obvious driver is that it has been harder for people to, if you like, service their group memberships, to go to their bowls club or their book club or whatever it is, to participate actively and enact with other people in the workplace. Really, it is pretty much across the board. One of the things that older people have, if you like, is more practice and they are better able to work around that. In that survey we noticed that young people are typically the people who have most group memberships because they are more socially active. We perceive that the idea that there has been a very significant drop in that age group is a real risk factor going forward because, as Cath was saying, we know that our group memberships are a source of resilience down the track. If you do not have, as it were, the money in the social bank, you do not have the capital to draw on when you are going to need it.

It is not a routine part of the analysis there, but it underlines this point that we believe group based social connections are absolutely critical to staving off loneliness because in many ways group based social connection is the antidote; it is the opposite of loneliness, if you like. What is the opposite of loneliness? It is not just social connection; it is group based social connection, and that relates to the fact that fundamentally we are social animals who live and have evolved to live in social groups.

Mr SKELTON: Do you think young people feel connected in this cyber area and have sort of turned their backs and that could be a driver of that?

Prof. A Haslam: I do not think that implicates that that statistic is right. We were not excluding digital group based connection from that analysis, so I think that is absolutely right. That is obviously a critical tool or instrument. Indeed, some of our colleagues in the UK have shown that group based gaming, for example, can be a very powerful way of connecting to other people. There is no inherent prejudice against those groups or suggesting that they are inherently inferior to face-to-face group activity.

Prof. C Haslam: One of the things that I think is really important to mention in the context of social media and technology for connection is that the message is becoming clearer that you need to have a balance. It is not just about all tech and it is not just about all in-person. A good balance between the two has better outcomes. I do not have data on young people, but there has been an interesting study recently, which is sociological data from the US and the UK, looking at people aged 65 and over and how they connected during and post COVID—in-person versus with technology. What they found was that people who did best—those with fewer mental health problems, who had better health in general and were happier—were those who actually had a balance of both. Having more tech and solely tech actually was worse for people's health. The balance is really important to get right.

Mr SKELTON: That is what I was driving at. From my own observations, I think there is a tendency for young people to be more reliant on tech and for older people it is the other way around, but once you introduce tech to the elderly they become familiar with it and they seem to find the balance. I think there is a definite trend among young people where they are not finding that balance. Those statistics that you have put forward allude to that.

CHAIR: Sadly, our time together has come to an end. The committee very much appreciates the contribution that you have made to our inquiry. We also appreciate the support and the encouragement that the University of Queensland and the Australian National University have provided for this tremendous initiative that we know is going to have some really positive outcomes for people across Queensland. We also know that it is an issue that has to be addressed. We thank you for your support, particularly today but also in the research that you do.

The secretariat just mentioned to me that the work we are doing tonight with our international colleagues will be broadcast live on Parliament TV. If you want to tune in between 5 pm and 7 pm, we will be talking with a number of international researchers. Thank you very much for your support and thanks again for giving up your time today.

DUNSTAN, Ms Libby, Chief Executive Officer, Brisbane North, Queensland Primary Health Network

MARTIN, Mr Paul, Executive Manager, Brisbane North, Queensland Primary Health Network

CHAIR: Welcome. Thank you for your time today. We wish you a good afternoon and we thank you sincerely for your contribution to our inquiry into social isolation and loneliness in Queensland. We ask you to make an opening statement, after which our committee will have some questions for you.

Ms Dunstan: Thank you very much for having us here today. Before we start, I would like to acknowledge the traditional custodians of the land on which we are meeting today. I would like to pay my respects to elders past, present and emerging.

We are from the Brisbane North Primary Health Network. There are seven PHNs, as we like to call them, in Queensland. Paul and I are here today representing the seven PHNs that cover the geographical area of Queensland. By way of introduction, I thought it would be important to articulate the role of a PHN. Many of you might have come across your local PHN in your constituency. In its simplest form, PHNs are funded by the Commonwealth Department of Health. Fundamentally, at the heart of what a PHN does is looking at understanding the local needs of a community. We each have a geographical boundary that we service. Our role is to understand the unique needs of those communities and to work in partnership with other organisations across that region, particularly with our hospital and health services but also with a whole range of health and community service providers, not only to improve health outcomes for the people in our particular communities but also to reduce fragmentation—to improve integration and to make sure that particular initiatives are targeted to the needs of the communities that we serve.

PHNs are commissioning agencies. The vast majority of funding that we receive is to look at commissioning services that meet particular local needs. From our perspective, that links really nicely into the local area needs assessment—identifying the need, understanding the capacity of the community, understanding what providers of services there are and commissioning services to meet those needs. A really big focus from the PHN's perspective is mental health. I am going to ask Paul to speak more specifically about that.

Mr Martin: As a primary health network our focus is on health and wellbeing, so we are looking at loneliness and isolation through that lens in particular. We absolutely recognise the impact that loneliness and isolation has on people's mental health and physical health but also the other way around: physical health and mental health can impact on people's ability to make connections and keep those connections. That is absolutely a core issue for us, although not particularly one that we are funded to deliver on. We mostly get funding downstream—so more clinical interventions, but through those clinical interventions we absolutely see isolation and loneliness as a key driver and complicating factor in people's mental health and wellbeing.

We think there are a range of services—in fact, quite a lot of services, opportunities, supports—informal and formal, that are out there but there are almost too many. It is too overwhelming for people, so there is a real need for service navigation and care coordination—how to help people connect to what they need and what they are interested in. Where you start is a big challenge that people have.

As a primary health network, you would not be surprised that we are going to focus on GPs. Eighty-three per cent of Australians visit a GP every year. GPs are an essential gateway into not just health services but also broader wellbeing services, if we can put it that way. Looking at what GPs can do in this role will be important.

The Commonwealth is developing a new 10-year primary healthcare strategy. It is looking at this notion of a 'medical home', particularly for people who have more chronic or complicated issues. They would have a home with a general practice and that general practice would be funded in a different way. Rather than funding people—for example, if I have an ingrown toenail, I rock up to my GP and get that sorted and the GP gets paid and off I go again. That works for ingrown toenails, but if you have a chronic illness that does not work. What you need is planned, proactive, ongoing care through general practice, and that needs to be funded in a different way. That notion of a 'medical home' is something that will be built on over the coming years. I think it might be useful particularly for those people who have more complicated issues.

As we said in our submission, as PHNs we are very much place based organisations. Looking at those place based responses to isolation and loneliness is obvious. Bringing multiple stakeholders together to agree on some shared objectives and work together in that way is core to what PHNs do. It is just bringing people together from health. We look at suicide prevention. All of the PHNs host a suicide prevention network or forum that has police, ambulance, community members, people with lived experience and service providers all coming together to agree on a way to go.

We absolutely support neighbourhood and community centres having a really strong role in isolation and loneliness or responding to that. As we noted in our submission, people do connect with their place but some people also connect with a community of interest. We look at resourcing those organisations and communities themselves who are about communities of interest so that people can choose one or the other or both.

We also recognise the digital divide. There is an opportunity for social media and the internet more broadly to address social isolation and loneliness, but it is a double-edged sword. There is that digital divide. People do not have access to it. Also, there are a lot of people who do not have the skills to navigate that and the implications of that, so building up people's online literacy would be helpful as well.

Finally, bringing people together by saying, 'Come along to a loneliness group and we will help you to stop being lonely,' might work for some people, but it is probably not going to work for most people. If you come along for something else—and we have suggested volunteering—without even knowing you start to make connections and friendships and so on. Putting more resources into volunteering in the range of different ways it can take we think is a good approach that will have a spin-off benefit of people building that connection, as well as the benefit that comes from their volunteering activities.

CHAIR: Thank you very much.

Mr BENNETT: I do not want to be controversial, but as a committee we have seen a lot of people doing a lot of wonderful things with limited budgets and a fragmented—that is my word—service delivery. With the Commonwealth playing a key role with state governments and not-for-profits, would you like to comment on how we can get some efficiencies with this considerable investment? It is about efficiencies. I am not saying that it is not well done, but PHNs have a real role to play. I think you are underestimated and undervalued in those conversations because you are the quiet achievers in terms of some of the money. I am interested in how we can get some efficiencies with the investment, particularly around targeted programs that we feel would make a difference in our communities that we are elected to represent.

Ms Dunstan: I think that is a really good question. It is certainly something that I think Paul has alluded to in terms of that place based approach. When I look at some of the things that PHNs are undertaking at the moment in terms of getting to the point of commissioning particular services, where do you start? You start by undertaking some joint planning and understanding what is occurring in a particular community. Each PHN and their corresponding hospital and health service has to have a regional plan around mental health. Let's not take mental health as a narrow definition. It can be a much broader definition. There is a whole range of things in our particular plan that address things like social isolation and connectedness with community as well.

In terms of those place based approaches, I think PHNs and HHSs working collectively together to identify what is the plan for a particular community and what are the services that have reduced fragmentation. Where we are commissioning is around where there are gaps or how we bring people together. Paul's point about navigation is also really important—how we connect people and help people to understand where the front door is. There should be no wrong door for people to access services or to connect to community groups and things like that. For a lot of people it is really difficult to navigate. That place based approach is critical from our perspective.

Mr BENNETT: We have heard a lot about that place based service. Everyone is different, so that is really important.

Ms Dunstan: What is going to work in Brisbane North is going to be really different from what is going to work in Western Queensland or in the cape. I think we have to have place based approaches that meet the needs of the communities that we serve.

Mr Martin: I think from a policy view, in developing some kind of strategy of actions in response to this issue we need to be clear about what is a Commonwealth responsibility, what is a state responsibility and what is best done at the local level. Oftentimes that will get mixed in together and it is just whatever somebody feels interested in and they run off and do it, but suddenly we have

three levels of government all doing the same thing and nothing is happening over here. Articulating that these are the things that the state government can drive at a state level but these are the things that are best driven and delivered at a local level is important.

The other thing on the service navigation is that I spent some time in the UK, where they have the Citizens Advice bureau model where people can go and get information and referrals on any topic. In Australia we have a mental health one, but you have to label yourself and then you have to go to a place that has that label and that is when you get help. We do not really have a place for generic help where you do not have to label yourself. You can just contact them to find out information about what is happening in your local community—informal supports as well as formal supports. There is something around how we do navigation differently that is not about splitting people up into disease groups or illness groups or social disadvantage groups; it is about citizens being able to find out what is happening in their local community.

Mr BENNETT: It is like a hub? Is that what you are talking about? We have heard a lot of that conversation and that is similar: they are under one roof or a one-stop shop. Is that what you are talking about?

Mr Martin: Yes. It is about that gateway into a range of different services and supports and that gateway being accessible for people and people not having to label themselves to access that gateway or perhaps people thinking, 'I'm going to out myself as a bit of a lonely person and I do not really want to do that so I am not going to go near something that has "loneliness" on the tin. But if it has a broader welcoming approach, I might go along to that.' Actually, a whole bunch of other people will go along to it for other things as well and then we get an efficient use of service navigation.

Service navigation is a bit of the flavour of the month at the moment, but what we have is a mental health service navigator, a nurse service navigator, an aged-care service navigator. They do not work together. They do their own thing. They have their own databases. Can we bring them together somehow and have a community navigator?

CHAIR: Certainly the UK model has come up before and we are very interested in it. It was called—

Mr Martin: The Citizens Advice bureau.

CHAIR: We will certainly make sure that we have the information we need around that.

Ms LUI: I do not know if this is a question or a comment. It follows on from what the member for Burnett said around the coordination approach with dealing with social isolation and loneliness. Throughout this public hearing we have spoken to a number of different entities who talked about the wonderful things that are happening in community. I fully agree with you when you say that if we pull it all together there can be capacity for, I guess, greater coverage in how we can deal with the issue moving forward.

I am trying to get my head around this in the remote setting as compared to all the organisations that we have visited in Toowoomba, Nambour and other places. Where there are limited services, that coordinated approach becomes beneficial. It is probably beneficial in bigger areas where there is a large number of services needing to work off the same page. I am not quite sure where I am going with this, but I am getting there.

We have heard from previous speakers this morning about the collective approach and group approach in getting people more connected. You mentioned volunteering, which I think is a good one, because when you start isolating people into categories, titles and labels, it takes the pressure away from the real issue at hand. Could you expand on the group idea or concept of addressing isolation and loneliness?

Mr Martin: In terms of the service navigation that I mentioned, think of it in a kind of a layered way. We should provide information to people about the services and supports that exist in the community because they have a right to know: it is taxpayers' money, it is their community and they should be able to access information. They should not need to go to a service to get that information. It is the wide provision of services and supports that are available in the community and the broad notion of that. When I say 'services and supports', the supports are all the informal things. It is the sporting groups, the Landcare groups and a whole range of different things where people can come together and do things together. However, because the world is complicated, it is difficult to navigate that. Having a place that you can go to for assistance in that navigation is the next layer. Whether that is a physical place, an online place, a telephone or a mixture of those, there is a layer that is about service navigation: 'I want to ring up and have a chat to somebody about what I am looking for and they can give me some suggestions in my local community.'

The next layer down, and this is fewer people, is that some people need a bit more support to do that. Just knowing where to go is not enough; they need some support to get them there. That might be transport support, but often it means the self-confidence to leave home and go into a group of people they have never met before and interact with them. In service land we would call that care coordination. A little bit of activity works with people over a period to support them to do the things they want to do with their lives. I think it is that kind of layered approach to service navigation.

In terms of groups, as I said before, it is that mixture of both place based and communities of interest. The starting point has to be, 'What are you interested in? What do you want to do with your life and how do we support that to happen?' There was a question earlier around outcomes. We had a program nationally called Partners in Recovery. It used an assessment tool called CANSAS, Camberwell Assessment of Need Short Appraisal Schedule. That had 30 or 31 different aspects of people's lives: housing, transport, relationships, sex, mental health and so on. It asked people: 'Is that going well for you at the moment? Not so well? Is it going pretty bad? What things do you want to work on?' Then every three months we would ask them how it was going. It actually is as simple as that. 'What do you want to work on? We can help you with that. Have things gotten better?' That is your outcome measure. It does not need to be overly complicated. It is starting with what people want and then helping to connect them with the things that are going to help them to achieve their goals and the things they want to do in their lives.

Ms Dunstan: The only thing I was going to add was to the first part of your question. As you absolutely have articulated, what it looks like in Brisbane north-west is very different from what it might look like in a remote community. There are some principles and frameworks that obviously we all work towards, but I guess place based approaches that understand the community itself—what is available in that community and what is going to work to support improved outcomes with that community—are the real unwritten potential of PHNs. We put that in our submission a little bit, around our agility and flexibility to understand that community and to look at what is going to work, because it will be different from community to community.

In the submission we have talked a little about some of the exemplars or some of the things that PHNs have undertaken in this space. When I think about the particular initiative that we are doing around looking at volunteer care navigators, we are working with CoDA Queensland to look at how we actually identify people over the age of 55 who work with their peers, to help them to not only access good health and wellbeing information but that broader focus on connection, social activity and engagement with the community. There is plenty of work happening. It is really about how we do that in a much more systematic and targeted way and utilise the resources that are already in the communities. The greatest resource sometimes is the individuals themselves.

Mr BERKMAN: A lot of the ideas we have discussed in your evidence, particularly around service navigation and care coordination, very much reflect some of the evidence we heard earlier today, specifically using the terminology 'link workers'. If I remember correctly, Inala Primary Care referred specifically to link workers in trying to perform that coordination role. Associate Professor Dingle and Dr Sharman from UQ talked about the importance of neighbourhood and community centres and their work having primary health networks overlaid on top of that. They said that there were not many link workers that they had seen. I think Dr Sharman said there were maybe 14 she had been able to identify doing that work. Can you speak to the prevalence or the absence of link workers, specifically in the Metro North PHN and more generally throughout the networks?

Mr Martin: Certainly we have the nurse navigators, which has been a big push over the past few years in the HHS system. I think each HHS has implemented those nurse navigators in a slightly different way. That would be a place to look at what that resource is and how it is being used. With all due respect to HHSs, which we love, sometimes they are a bit inward looking, and so too is the navigation in amongst their own service delivery within the HHS. Certainly we have been successful in working with our HHS around what are the links outside the HHS to the community and what role those nurse navigators can have in connecting people to outside services.

We have a service called Team Care Coordination, funded by the HHS and Queensland Health for over 20 years for people with chronic illness. The GPs and the hospitals can refer people to our team care coordinators, which is a team of nurses. They will go out and do home visits, assess what the person's needs are, including their broader health and wellbeing needs, and help them to connect to those. That has had a number of evaluations over the years and has shown to be very successful.

In the mental health area, a number of PHNs either directly, as we do, employ or fund an organisation to be in effect the service navigators for mental health. That is through telephone and online and that model that I described earlier. People can access that service and get support to connect with mental health services. Once again, it is an example of where you have the mental health happening here and then we have similar for aged care but what we do not have is the generic.

I think there are actually more people doing service navigation and linking; there just are not very many people whose job title is that. How can we resource that to happen? How can we do that service navigation or linking in a good way? What are the databases that we can use so that every organisation does not have to establish their own database of local services but we have a central one? Is there a statewide website that we could have that breaks down into local areas? How can that link work be resourced? You have to have a mixture of people whose primary job is to do link work but also say that linking people to what they need is a job for everybody, for all service providers, and look at how we can support them to do that.

Mr BERKMAN: From what you are saying it sounds as though, if we are going to have workers in other more discrete roles providing that linking service, they need the resources, whether that is something as simple as a database or an additional office to contact to ensure they are coordinating it.

Mr Martin: Hopefully, in primary care specifically, that notion of the medical home and the different way of funding will make that a bit easier. You could see in a general practice that there would be either a nurse or a social worker who can play that link worker role. At the moment, that is really difficult for general practice to fund because the MBS funds them for activities and link work is not an activity that they get funded for. Some will find ways of funding that, but most are not able to. With this medical home approach, the plan is that you would have a predictable amount of income that you could spend on supporting people's health and wellbeing that is not just about individual items of service delivery. There is potential there for that link work to be part of that medical home model.

Ms Dunstan: Earlier I talked a little about a PHN's role in undertaking local needs assessments and understanding the needs of the community. There is the health and wellbeing needs, and I guess the much broader social determinants of health are a newer space, particularly for primary care providers. It is how that is funded and resourced, recognising that at the moment it probably is a bit siloed. It is not that there is not those support services there, but it is not happening in a planned and coordinated way.

Mr BENNETT: Paul, thanks for that last bit of clarity, because 83 per cent of people present to GPs, as you mentioned earlier, and their technology platforms are fairly uniform now. Your point about using technology platforms could be addressed as a simple way of getting that done.

Mr Martin: In fact, the PHNs provide a platform called HealthPathways, which is a clinical management tool. If you have a particular clinical issue, depression for example, the GP can go onto that website and there is a clinical management pathway about how to support somebody through depression. That includes links to services and supports. Those pathways, while they started off being quite clinical, have moved to broader wellbeing pathways as well. There is a platform for GPs that could be further expanded for this purpose.

Mr BENNETT: Thank you. That is very informative.

CHAIR: The insights you have been able to provide certainly raise a whole heap of questions for us around how, as the deputy chair mentioned, we can coordinate our funding, capacity and resources to work more efficiently across governments, both federal and state governments. Thank you sincerely for your insight and your time today. We really appreciate what you have been able to provide our committee. Thanks again for giving up your valuable time. We appreciate it.

That concludes this hearing. On behalf of the committee, I thank all the witnesses and stakeholders who have participated today. I also take this opportunity to thank the many submitters who have engaged with our inquiry to date. Thank you to our Hansard reporters, as always. A transcript of these proceedings will be available on the committee's parliamentary webpage in due course. I now declare the public hearing closed.

The committee adjourned at 1.00 pm.