COMMUNITY SUPPORT AND SERVICES COMMITTEE

Members present:
Ms CP McMillan MP—Chair
Mr MC Berkman MP
Ms CL Lui MP
Mr TL Mander 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

WEDNESDAY, 20 OCTOBER 2021

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The committee met at 10.28 am.

CHAIR: Good morning, everyone. 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, the Djabugay people and the Yirriganydji people, and pay our respects to elders past, present and emerging. I also acknowledge my great colleague the member for Cook, Cynthia Lui MP, who is a First Nations woman and a well-respected member of our Queensland parliament. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander peoples, whose lands, winds and waters we all are so lucky to share.

On 27 May 2021 the inquiry into social isolation and loneliness in Queensland was referred to this committee for examination, with a reporting date of 6 December 2021. My name is Corrine McMillan. I am the member for Mansfield and chair of this committee. Mr Stephen Bennett, the member for Burnett, is the deputy chair and unfortunately cannot be with us this morning. The other committee members with me today are: Mr Michael Berkman, member for Maiwar; Mr Robert Skelton, member for Nicklin; Ms Cynthia Lui, member for Cook; and we are fortunate to have Mr Tim Mander, member for Everton, who is here today substituting for Mr Jon Krause MP, member for Scenic Rim, who sadly cannot be us with today.

The purpose of today's hearing is to assist the committee with its inquiry into social isolation and loneliness in Queensland. The committee is a committee of the Queensland parliament and its hearings are subject to the rules of the parliament. We are in Cairns today to hear the views of our community. Please take this opportunity to share with us your thoughts and your experiences. Our committee welcomes your views and certainly acknowledges the great contribution you make to dealing with this issue every day in Queensland.

I ask that everyone respect the views of others to hold and express their particular view. When speaking, please take care not to refer to ongoing court matters or to the naming of children. The hearing is being recorded and transcribed by Hansard and speakers should be aware that the transcript of this hearing will be published on our webpage. For any media present, I ask that you adhere to my directions as chair at all times. The media rules endorsed by the committee are available from committee staff if required. Please also note that you may be filmed or photographed and that images may also appear on the parliament's website or social media pages. Please advise us, of course, if there is any issue for you regarding this. I ask everyone present to turn mobile phones off or to silent mode.

WARREN, Dr Shane, Lecturer, School of Public Health and Social Work, QUT (via videoconference)

CHAIR: Good morning, Dr Warren. I ask you to make a brief opening statement, after which our committee members will have some questions for you.

Dr Warren: Thank you very much, Chair, and thank you to the committee for this opportunity to speak with you this morning about our submission. I also acknowledge the traditional owners of the lands on which we are all meeting. I am coming to you today from Turrbal and Jagera country here at Kelvin Grove. I want to acknowledge elders past, present and emerging, recognise the role that Aboriginal and Torres Strait Islander people continue to play within the QUT community and recognise that these lands were always places of teaching, learning and research.

Thank you, again, for this opportunity. I will say just a little bit about ourselves. I represent the area of social work within the School of Public Health and Social Work at QUT and also our newly merged Centre for Social Change, which I will talk about in a few moments. Our school is very much grounded in critical social work perspectives. These are really important to us in relation to achieving greater social and environmental justice. Our school is also committed to advocacy, activism and giving voice to community members and groups who face great challenges in relation to social inclusion.

Each year we place approximately 450 human services and social work students with our industry partners in government and non-government agencies across all fields of practice. We have a great deal of experience and perspective around this really important topic of social isolation and loneliness. The last two years of the pandemic have certainly created lots of challenges for us—as it has for I think every sector—but they have also provided us with some unique opportunities in relation to how we go about field education. There is also a unique perspective on social isolation and loneliness.

QUT has recently launched the Centre for Social Change. This brings together social work students, academics, researchers and partner agencies as we engage in direct and indirect critical social work practices. Some of the examples of recent advocacy works that we have been involved in include animal inclusive social work, the Biloela Bringing them Home project, a peacebuilding project and lots of work to do with universal basic income.

Moving on to our submission, this was an opportunity for students from the Centre for Social Change to work with academics to really explore the issues of social isolation and loneliness. The common threads for all of us—hopefully they came through in our submission—were that the issues around marginalisation, oppression and disenfranchisement from the community or different community members are really at the heart and the focus of our submission. Social isolation and loneliness for us are very much about the quality of human connection and the role of community and the formal service system in bringing about meaningful connections for community members, especially for community members who have experienced great marginalisation and oppression.

Social justice principles of access and equity are paramount for us in any of the policy and service delivery design processes to address social isolation and loneliness. Our experience and analysis shows that initiatives that work best are those with no or very low access requirements. Examples of what I am talking about here include where there are not waiting lists being used by service providers and certainly no fees or costs associated with accessing the service. Those access and equity principles are really critical for us.

In our submission we also wanted to broaden the discourse around social isolation and loneliness. When we reviewed the literature we found that a lot of literature focuses on seniors and elderly Australians. That is absolutely an important demographic group. In our practice experience, we also wanted to highlight the issues for First Nations communities, culturally and linguistically diverse communities, rural and farming communities, and young people, in the broadest context, as some of the groups that we were particularly focused on. That is certainly not exhaustive either.

In our submission we also spoke of a range of existing service providers—some newly emerging providers as well—that are dealing with social isolation and loneliness with different cohort groups. We particularly wanted to highlight the work of community hubs and the community neighbourhood centres and absolutely recognise the important work the Queensland government has been doing in relation to improving and really revitalising neighbourhood centres and community centres right throughout Queensland. We also wanted to really focus on the web of community hubs, where a lot of our direct practice occurs for people experiencing different forms of isolation and exclusion.

Mr MANDER: Thanks, Dr Warren, for your comprehensive submission. This is a little bit left field, and I do not know if you have had a chance to consider this. Is the issue of social isolation and loneliness more prevalent in Western civilisations where it could be argued that society is a bit more individualistic, the extended family is not practised as much as it may have been in other cultures and some of the social institutions have broken down? I do not know if you have had a chance to make those sorts of wider observations. Of course it is not just in Western culture, but does Western culture have more prevalence of this issue?

Dr Warren: Any culture that has gone down the track of rampant consumerism and global capitalism—we have seen a lot of threats to community and community networks and bonds between communities. I think there are certainly challenges there for a lot of different urban, regional, metropolitan and rural and remote communities as a result of some of those processes and some of those threats to community networks and community bonds. I think you are right when you assert a real rise in individualism being very much a part of that threat to community.

Ms LUI: Thank you, Dr Warren. It is good to hear from you this morning. Thank you for your contribution to this public inquiry. You have mentioned some of the vulnerable groups or cohorts in community. It just highlights the diversity of the groups that are most vulnerable to social isolation and loneliness. Do you have any ideas or suggestions around how we could get more community participation and get more community involved in community activities or events moving forward?

One of the things that has come out of a lot of our public hearings is that there is a disconnected community. I am trying to get your thoughts around how we engage more people to be socially active in community.

Dr Warren: I would certainly go back to the principles around access and equity and making sure that in any policy or service delivery design we minimise access issues. When initiatives are designed and implemented there are often lots of access criteria, and people wonder if it is something they are able to be involved in. We have to make sure the access criteria are simple and absolutely minimal. We are big fans of what the community hubs do in parts of Queensland, especially the way they offer support to people to be able to drop in, be involved in a mothers group or a playgroup and get involved in other information sessions about relevant topics to do with the community and families. It is about really thinking about those access and equity issues.

We really need to be listening to First Nations communities and elders a lot more in this process. Community development and community work is part of the area that I teach in and I am very committed to principles around bottom-up community development and working with people at a grassroots level. We also think the principle of community embeddedness is really important here. Again, I think that is an element that needs to come through strongly in any policy or service delivery design.

Mr BERKMAN: Thank you, Dr Warren, for joining us. I really appreciate your time today. I am interested in your take on the proposed solutions of social prescribing and the use of link workers. We have heard a bit, particularly from folks in the UK who are actually using social prescribing as a part of practice in addressing social isolation and loneliness now. Link workers, as they described them, are integral to bringing together different community services. Has your work looked at that and what potential do you see for that sort of structured response in Queensland?

Dr Warren: I am familiar with the work in the UK around social prescription and the models that they have whereby social workers are based in GP clinics to try and promote greater connection with community networks and support services. The principle is one that has a lot of merit. I am also familiar that the Queensland Community Alliance has done an incredible amount of advocacy around this issue and particular models.

There is scope to be considering learnings from the UK. Professionally, whether it is done in exactly the same way as the UK is up for discussion. I do not want to see issues become medicalised where they do not need to be. I think that is a challenge in terms of how you go about the policy design in this space. Obviously it works very well in a range of United Kingdom communities, but how we approach that here might look and feel a bit different.

Mr BERKMAN: I really appreciate your response there. They are interesting ideas. It ties in very much with what you have already presented around the importance of neighbourhood and community centres. Countless other witnesses have gone directly to their existing function in building community but also as part of a response to social isolation and loneliness. This is a very long preamble to my question. The folks in the UK flagged one of the risks around social prescribing. If the facilities that we are looking to connect people with, whether it is through a grassroots, bottom-up kind of response or that medicalised social prescribing approach—if those neighbourhood and community centres and other facilities are not adequately resourced then the whole response is doomed to fail. Can you add any thoughts along those lines?

Dr Warren: I absolutely agree. I have many friends and colleagues who work as hospital social workers and have done for many years. When you are working with people in those environments and you are trying to initiate referrals and appropriate referrals, often there are assumptions that there is a community support service available. Certainly we have seen in different periods and under previous governments where that was a lot more challenging, the funding for community support services. Part of the issue here is also that there needs to be services and supports that are available and making sure that there are not assumptions that the supply of services is there or is adequate.

CHAIR: Dr Warren, our colleagues from Griffith University, the Queensland University of Technology and the University of Queensland have been incredibly and humbly generous with their contributions to our committee. We appreciate immensely the work that you as academics do in research. As a government we always try to embed policy bills in contemporary research. Could you comment on the role potentially of a social isolation and loneliness framework being established? What would be the risks and the benefits associated with such a framework?

Dr Warren: That is an excellent question. It is really worthwhile policy work that does need to happen. Social isolation and loneliness have been issues in Australian society for many years now, with many of the drivers that we have been talking about in this conversation but also with the issues

associated with the pandemic over the past two years. Anything that can be done in terms of policy work to support a robust prevention of social isolation and loneliness framework would be really well worth the effort.

CHAIR: Dr Warren, sadly our time has come to an end. We do appreciate the great work that you as an academic do in this field. Certainly we would not be able to do our work without the support of QUT, UQ and Griffith University. Thank you immensely for your time this morning. Keep up the great work that you do. Know that the work that you do as a researcher is incredibly valuable to the work that we are doing. We look forward to our continued work.

Dr Warren: Thank you very much for your time this morning, committee.

FEJO, Ms Miriam, Cultural Practice Adviser, Mareeba Community Centre

MAST, Ms Erica, Community Connect Worker, Mossman Support Services

McGILLIVRAY-TAYLOR, Ms Heather, Manager, Mossman Support Services

THEAKSTON, Ms Julie, Manager, Mareeba Community Centre

TRAVERS, Ms Emma, Manager, Port Douglas Community Service Network

WILKINSON, Ms Ashlee, Mareeba Community Centre

CHAIR: I now welcome representatives from the Mossman Support Services, the Mareeba Community Centre and the Port Douglas Community Service Network. Ladies, it is great to have you appear before our committee to share your tremendous expertise and experience with this issue. I wish you a very good morning and I thank you for appearing before the committee today. I will ask each of the centres to make a brief opening statement and then our committee will have some great questions for you. The time allocated to this session is 15 minutes. We will try to manage our time as best we can, but perhaps I will be able to steal a few minutes from the next session. We will see how we go. Can you please give a brief opening statement of two minutes or so and then we will follow up with some questions?

Ms Fejo: Mareeba is a regional town about an hour's drive from Cairns. It has a low socio-economic status and a high Aboriginal and Torres Strait Islander population. Our organisation has been operating for about 30 years and our programs are largely focused on the Mareeba Shire Council area. Additional to neighbourhood centre funding, we currently run six other government funded programs. Our neighbourhood centre funding gives capacity for one full-time employment position and with this we have assisted over 1,000 community members in the last quarter, providing services including information, advice and referrals; assistance with reports and forms; free computer and internet access; office space, meeting and training rooms; a community pantry; a work-for-the-dole scheme; self-help and support groups; and community events and activities.

The key points we make today are that neighbourhood centres are pivotal in addressing loneliness and social isolation and that a more equitable investment into these centres is essential. One of the most important features of neighbourhood centres is that they are place based, both relatively and strategically. We understand our communities. We work collaboratively with other organisations. This means we can mobilise quickly to meet immediate needs and address systemic issues.

An example of this was mid last year when COVID restrictions were announced. We sit on the community wellbeing subgroup of the local disaster management group. At the meeting the police expressed concern that many of our Indigenous community members seemed to have minimal knowledge of existing and increasingly stringent restrictions. Our service facilitated a partnership with the police and the Aboriginal health service to doorknock over 450 homes in the more vulnerable geographic areas of Mareeba. This task was completed within three days of the meeting.

Neighbourhood centre funding across the state is not remotely sufficient to cover the breadth of the need within each community. We believe this is one of the reasons that loneliness and social isolation are increasing. With a minimal capacity to employ staff in our neighbourhood centre, we have taken many other steps to bolster our own financial sustainability. While many of these are effective, they also leave us vulnerable and dependent on items outside of the scope of the neighbourhood centre itself.

Resourcing for infrastructure seems haphazard at times and dependent on politically based agendas rather than on hard evidence of community needs. Mareeba has had a purpose-built community service hub on the DCHDE infrastructure priority list for many years but it continues to be shelved. This is despite our local council's support to provide us with land for the purpose. Our organisation has always paid market rent for premises and currently this equates to $42,000 per year. Additionally, we estimate that our relocation costs over the years have been about $180,000 in total. That money could have been better spent in direct service provision.

Thank you for exploring the reasons for and the possible answers to loneliness and social isolation. It is our hope that the outcome of this inquiry will result in neighbourhood centres being highly valued, prioritised and resourced better in the future. Thank you very much.

Ms McGillivray-Taylor: We provide a wide range of programs and services from our premises to meet the needs and interests of our diverse community. Situated an hour's drive north of Cairns, Mossman is a rural/remote area where the challenges presented are the higher costs for goods, lower pay, a housing shortage, higher rents and less immediate access to specialised services. These factors further impact the effects of loneliness and isolation that the vulnerable and disconnected are facing.

Neighbourhood centres meet the needs of people who feel disconnected and excluded and who experience poor mental health and wellbeing by helping them connect and receive support to develop effective and sustainable life outcomes. Due to the pandemic and ongoing restrictions, individuals in our community are needing even more assistance in these areas. The significant financial impact in our area as well as the challenges of extended family being unable to come up to support individuals facing complex issues when they usually would are further exacerbating isolation and loneliness.

Programs are designed and recommended using a person centred approach by having discussions about interests, strengths, goals and ambitions. The programs offer a tool for guided discussion that gives the individual some confidence when attending, helping them to overcome barriers for community involvement and meeting people with common interests or experiences, as well as broadening their understanding of other people's life experiences. Increased government investment in neighbourhood centres and strong delivery in turn will save on the need for governmental spending at crisis point in areas of mental health services, crime and policing, and alcohol and other drugs in the future.

Ms Travers: Good morning and thank you for the opportunity to speak today. I would like to acknowledge the traditional owners of the land on which we meet and elders past, present and emerging. The Port Douglas Community Service Network is 32 years old. Our vision is to build an empowered, resilient and sustainable community. Our neighbourhood centre offers activities that build community connection in things like English conversations, meditation, men's breakfasts, technology classes, cooking on a budget and community lunches. We provide emergency relief by helping people with food, fuel, medication and transport. We also help with things like housing applications and navigating myGov.

We offer no-interest loans. Our program has lent over $1 million in the past 10 years. This program has made a huge difference, especially to our Indigenous community, reducing reliance on payday loans and building financial resilience. We also operate an op shop and child and parent support programs. People come to our centre to access Centrelink, visit their job network provider, attend Alcoholics Anonymous, see a JP, get their hearing tested and myriad other services that are not offered anywhere else in our little community.

The community we service is diverse. We have a high population of seniors, our local Indigenous community, domestic and international travellers, itinerant workers, young families and a steady stream of southerners moving to our beautiful area. Our tourism-reliant town has been hit hard by border closures. We have seen new cohorts of people coming to us for help, particularly those working in or operating small businesses in hospitality. As a place based service we need to be fluid and flexible to provide the help our community needs, no matter what life throws at them.

Our community will come and talk to our staff and volunteers when they are feeling hopeless, when they are thinking about suicide, when their washing machine breaks down, when they are hungry, when they are trying to make sense of government correspondence but most of all when they do not want to feel alone. We have a fantastic group of about 50 volunteers who value the opportunity to connect and make a difference in their community. We see such significant improvement in the mental health and wellbeing of people who find a meaningful volunteer role that harnesses their skills.

I came to this role after 13 years in the Public Service. In reading previous submissions to the inquiry, I reflected on my experiences and the benefit of a funding model that supports place based neighbourhood and community centres, and our staff, who have local networks, know our community and understand the challenges and opportunities. The support we need to continue and build on our work combatting social isolation and loneliness falls into two areas: human resources and infrastructure.

Our staff drive the service and the service supports the community, but our staff need support and security to do their work. As a manager, much of my time is spent dealing with resourcing and infrastructure issues. An example is the lack of public transport in our area. Those without a car pay upwards of $80 return to get to Mossman, which is 20 kilometres away, to access medical services,

go to Centrelink or attend court. What a difference a government leased minibus would make to our community and to our centre. There are other infrastructure issues: reliable IT systems, solar panels, generators, kitchen facilities and adequate security systems. Some of those problems could be so easily fixed and have such an impact.

With secure funding and improved access to infrastructure, our centres, our people and our communities would be more resilient. We are already here doing the work. We have limitless possibilities but we are vulnerable because of our limited resources.

CHAIR: Emma, thank you. I congratulate and thank you all for the work that you do each and every day supporting your communities. We are hearing everywhere we go the challenges that you articulated so very well, Emma. We are hearing very similar messages wherever we have visited throughout Queensland. We value the work that you do and we recognise the great impact that you have in your communities. Thank you sincerely on behalf of the committee.

Mr MANDER: Thank you, ladies, for what you do. My neighbourhood centre is very much appreciated in my area in Brisbane—different needs, different demands but still very much appreciated. I have just joined this committee so excuse my ignorance. I am just looking at your recommendations, increasing to a minimum of 2.5 workers. What does the current funding cover?

Ms McGillivray-Taylor: It would depend on each one. Currently in our service the funding covers 1.2 staff.

Mr MANDER: Is that typical?

Ms Theakston: Yes. It is about one FTE across the state.

Mr MANDER: What does the strength based awareness campaign look like? What would have to happen for that to take place?

Ms Theakston: My understanding is that that would be facilitated by the peak body, which is currently the Queensland Families and Communities Association, changing the name to Neighbourhood Centres Queensland, I believe, in December. That would be looking at the roles of neighbourhood centres within each community and being able to reinforce that across the state. It is not so much aimed at specific communities.

Mr MANDER: A promotional communication strategy?

Ms Theakston: Absolutely, over all of Queensland, yes. That is my understanding anyway.

Ms LUI: Thank you, all of you, for being here today. My question is around the access to services and equity issues. Our previous speaker touched on it. I am interested to know your thoughts around it more specifically in relation to regional and remote communities. What are your thoughts around issues of access to services and addressing the challenges around equity?

Ms Mast: I am the Community Connect worker at Mossman Support Services. My role in the community is access. Government funding allows 12 Community Connect workers to exist within the state of Queensland. The Douglas shire is very lucky in that we have a representative in this role. My intention is to assess any individual in my community, unpack all of the conflict and the traumas that they are going through and then help them access to the best line of services for them. The difficulty is in receiving services.

I cannot speak on the Mareeba situation, but essentially anything north of Palm Cove is very hard to get touch to. Not only is there a limited number of service providers; those service providers that we might bring up from Cairns are not interested in driving that far north. There is not a large selection of telehealth connection for people. This means that often I have individuals coming to me with whatever problem they are presenting with and my difficulty in supporting them is saying, 'I see your problem. I believe these are the areas of support that we need to contact. Unfortunately, there is a huge waiting list. We need to get you to Cairns.'

I am very lucky in that I have a large brokerage that comes with my position that I can use to find these services, but that brokerage is not bottomless so I also have to be mindful who I support and what level of support I am able to provide to them. Access is the hardest point. We are lucky that the community service organisations that are running have fantastic programs. We have group programs for new mothers who would otherwise be isolated, because it is very lonely when it is just you and your baby. We have programs for our homeless cohort. We have a soft entry point for people facing homelessness, just so they can regain that dignity and feel like a person. We have community lunches and sewing groups. We have a plethora of programs—that is, if they can get to us. A lot of them cannot because the transportation concern is the biggest access issue.

We have collaborated as a community service organisation. There are about five different community service groups in the Douglas shire that have worked very hard in the last eight months to develop a transportation program which is running its trial right now. Fingers crossed that goes well. Access is not limited because we do not know; it is because we do not have resources.

CHAIR: Thank you, Erica. That certainly supports the research coming out of QUT.

Mr BERKMAN: I do appreciate your time. We could spend ages with you, but obviously time is limited. There is amazing work going on in all the centres. It seems like the more remote neighbourhood and community centres have more infrastructure needs. The funding for the physical infrastructure or for support services like the transport needs of the community are more acute the more regional you are. Is it the case, as the QFCA asks, that staffing resources are still absolutely your No. 1 priority? How are you balancing the need for infrastructure funding and support as opposed to staff time?

Ms Theakston: That is a very good question. Can I just jump back quickly to the previous question? One of the things that I think is really key in access, particularly for the more remote and regional communities, is having place based services. Travelling services do not cut it for our community. They want to be able to walk in; they want to see people they know. Relationships are absolutely vital. If people do not have someone on the ground that they can go to then they just do not go anywhere. That is what we find more and more often. I think the department of communities' motto of 'no wrong door' is a really key thing that we really need to push as a sector. Basically, people should be able to walk in somewhere and that starts the process of linking them in, yes.

Going back to your question, from our point of view I think it would actually be really difficult to say, quite honestly. A lot of neighbourhood centres do have their own infrastructure, so I think a lot of those would obviously say the staffing is an issue. However, for us, the amount of money we spend on rent potentially could employ people for a period of time. I think they are both really crucial.

CHAIR: Thank you, ladies. Sadly our time has come to an end. I concur with my colleague the member for Maiwar: we could spend all afternoon talking with you about some of the complexities and some of the challenges and the recommendations that you have made as a result of your experience and expertise. Thank you for your submissions. Thank you for coming and speaking with us today. We really do appreciate the work that you do. We understand how hard it is. Having been a public servant for 25 years and continuing to be a public servant, I know that the social services and the public service sector is hard work. The work you do is so appreciated by our committee. Thank you sincerely. We do hope that this inquiry will make a difference. Thank you again. Be sure to keep in touch.

Ms McGillivray-Taylor: May I give you each something to take away? It is reading.

CHAIR: I ask that the committee provide leave in order for Heather McGillivray-Taylor from Mossman Support Services to table a document. Thank you sincerely for that. We will most definitely read it. Please keep in touch with our inquiry. Should you have any further contributions, recommendations or suggestions—if you get home and you think, 'I should have mentioned X, Y or Z'—please email me as committee chair or email the committee. We will welcome any further insight that you have. Thank you, ladies. It has been a real pleasure to meet you. Is leave granted to table and publish this document? Leave is granted.

CADET-JAMES, Ms Yvonne, Research Coordinator, Apunipima Cape York Health Council

CLIVE, Ms Frankie, Chief Executive Primary Health Care, Apunipima Cape York Health Council

CHAIR: Good morning to you both. We acknowledge you as First Nations people and we pay our respects to both of you for the wonderful stewardship and leadership that you provide to our country. Thank you sincerely. I will ask that you make a brief opening statement, and then I am sure our committee will have many questions for you.

Ms Clive: Thank you, committee, firstly, for the opportunity to provide a submission to be tabled. We are very honoured to be here. I will say just a little bit about Apunipima Cape York Health Council. It is a community controlled organisation that is espoused in a community governance model where the representatives of our board and our health action teams are community based. We service and provide comprehensive primary health care across 11 communities in Cape York and we also provide a mix of clinical and non-clinical services. Before I go on, I will acknowledge the traditional owners of the land on which we are having this meeting, the Gimuy, Wallubara, Yidinji peoples, and pay my respects to elders past, present and emerging. I would also like to acknowledge the traditional owners of the lands on which we provide services across the beautiful country of Cape York.

Apunipima's model of care is a family centred model of care. It recognises individuals as a part of a connected clan, kinship or family structure. It is a holistic and opportunistic integrated comprehensive primary healthcare model. Outside of service delivery of clinical and non-clinical primary health care we do undertake research and advocacy on behalf of those communities. Our holistic model requires that we interface and recognise and acknowledge the impact of environmental, social, economic and cultural determinants that impact on health outcomes and quality of life. Our work is broad and is inclusive of those needs of the community. Our submission will focus more on an academic and literature review but also anecdotal information from our service providers and our staff and clinicians who are on the ground. I will hand over to Yvonne.

Ms Cadet-James: Thank you to the committee for the opportunity to talk here today. I also acknowledge the traditional custodians of the lands on which we meet today and where we provide our services. It is well documented that many Aboriginal and Torres Strait Islander people are in the category of vulnerable and disadvantaged at various stages of their lives or sometimes for their whole life due to the ongoing impact of colonisation, social policies, political agendas, denial of language and culture practice, loss of rights to traditional land, removal of children, breakdown of kinship and family structures, intergenerational trauma and racism. As a result this impact, the social determinants of health and wellbeing which affect education and employment mean that the environmental and circumstances in which many people live perpetuate social isolation and loneliness.

Aboriginal and Torres Strait Islander people's existence depends on kinship connection to each other and to the land, seas, waters and environment and associated cultural responsibilities and obligations. Denial of these cultural practices causes breakdown in kinship, cultural responsibilities and obligations, as does social isolation and loneliness through family separation, lack of identity and lack of purpose in life. A focus on the cultural determinants of health and wellbeing promotes a strength based perspective, acknowledging that strong connections through kinship and cultural and traditional lands build and strengthen individual and collective identities and resilience and promote social inclusion rather than exclusion and loneliness.

A general commitment to addressing social exclusion and loneliness requires listening to and working with Aboriginal and Torres Strait Islander people and providing people with the means and capacity to identify their own issues and solutions to these issues, particularly at the local level. A bigger commitment needs to come from all levels of government in well-run programs and services because a combined approach to the issue needs to be adhered to.

CHAIR: Thank you, Aunty Yvonne. You have very clearly articulated one of the major issues in relation to this complex issue of social isolation and loneliness—that being the social determinants of health. I have been really encouraged to hear your expansion of those to include the cultural determinants of health. Thank you for such a well-articulated description and statement. The work of our committee so far has focused a lot on what you have shared. Thank you sincerely. Well done to you.

Mr MANDER: Thank you for the work that you are doing. I am interested in your submission and in some of the suggestions that you have made. I would love to know more about the family wellbeing empowerment program. Would you mind expanding on what that looks like and how that can be used even more widely?

Ms Cadet-James: The Family Wellbeing Program was developed by Aboriginal people in South Australia many years ago where people of the stolen generation were concerned about local issues. They got together and thought about how that might provide leadership in dealing with those issues. They approached the local RTO and through that became the Family Wellbeing Program, which is offered at certificate II level through TAFEs.

I have been involved with the program now for some 20 years. It is a program that provides a structured approach to working with small groups of people. It gives them the confidence and skills to identify their own issues and, more importantly, the solution to those issues. That might be personal, family, community based or even structural approaches such as having their own community based health centres or other centres associated with health and wellbeing. There is a lot of information. It has been systematically valued over the last 20 years. There are many publications that show evidence of very positive outcomes.

Mr SKELTON: Obviously we want location-specific strategies because every community is different, but are there benefits to a statewide strategy to address social isolation and loneliness?

Ms Clive: Yes. I would see that there would be some benefit to a statewide strategy to address those issues. I think it enables service providers that have a unique context and location to customise and enrich solutions to put forward. I think a statewide strategy also enables people to have a shared platform in which they can come together to share best practice which I think is probably missing in this space.

We would appreciate some guidance as to how we may be able to provide more comprehensive integrated care. We do have social and emotional wellbeing programs that are run out of four sites specifically across the cape. Some of the difficulty in having those separate community based services is that there is not a common ground for communities to come together to have a yarn about what the common issues might be so we can be a bit more systematic in our approaches and learn from other organisations about what they have found, particularly around the challenges in very remote contexts.

Mr SKELTON: With regard to the direction of having a strategy, it is also a chance to build networks.

Mr BERKMAN: We really appreciate you being here today and bringing your experience from all across the cape. You have touched on this a bit already. Can you give us a sense of what the non-clinical services that you offer look like generally? What is the split between the amount of work the organisation does in a clinical medical context and those broader non-clinical services?

Ms Clive: It is really hard to split that down the middle. We certainly do have our clinical services that are our general practitioners, our nurses, our midwives and our Indigenous health practitioners and health workers who work on the ground. I think currently across the organisation you are probably looking at a workforce of about 60. Our current overall workforce is just shy of 300. I think it is about 250 overall.

The non-clinical services are really centred around our Social Emotional Wellbeing program and there is significant investment across a multitude of funders for that. We do have currently about 60 staff who are employed. They manage programs around cultural connections for post-release prisoners, the social and emotional wellbeing centres themselves and men’s support programs.

Our model is predicated on being an opportunistic care model. The difficulty for us—and something in terms of social prescribing that we would like to have a look at—is how we provide better integration so that there is a better continuity of care for a person experiencing any of the hardships that social isolation might cause for them. That includes the ability to refer out to other agencies and other services that we provide.

We also have allied health practitioners on the ground—podiatrists. Obviously we are dealing with the burdens of chronic disease as well. That in itself can create issues in terms of social isolation where people have to travel to Cairns due to the limited access in the cape and are often found to be away from their family and the strength based family structures that they need to help them to get through those issues.

I would probably hazard a guess that a large proportion of our primary healthcare workforce is non-clinical. I know that at least half of our workforce is community based. That is what we intend to continue to increase as we recognise that communities are well aware of the contexts and issues that are on the ground.

Mr BERKMAN: That is really helpful. Thank you.

CHAIR: That is certainly a powerful response. Sadly, our time has come to an end. Again, we could spend so much time talking with you. One the great challenges you have compounding the social isolation and loneliness issue is the geographic location and distance between communities—the vast and barren country that we live in. Thank you sincerely for the work you do in the cape. We absolutely value that work and we value what you do for your communities. Thank you for giving up your time this morning. We know that you are very busy people.

BROWN, Ms Elizabeth, Chief Executive Officer, Access Community Housing Company

VIDAFAR, Ms Jessica, General Manager, Access Community Housing Company

CHAIR: Good morning to you both. Thank you very much for appearing before our committee this morning. The committee is very much looking forward to hearing an opening statement from you, after which our committee will have some great questions.

Ms Brown: Thank you to the committee for the opportunity to meet with you and speak with you this morning. We would also like to acknowledge the traditional owners of the land on which we meet today and pay our respects to elders past, present and emerging.

Access Community Housing is the largest community housing provider in Far North Queensland and has been operating for 30 years. We have nearly 650 properties that we manage with over 1,200 tenants across Far North Queensland, extending from Mossman to Babinda. We provide social housing to people who meet the eligibility criteria from the Department of Communities, Housing and Digital Economy.

The demographic of our tenants is that nearly 80 per cent of our tenants identify as Aboriginal and Torres Strait Islander people, 25 per cent of our tenants are elderly and 25 per cent of people would be in receipt of the disability allowance. Certainly over the last 12 to 18 months we have seen a significant increase in the demand for social housing. The increase in rents in the area of up to 10 per cent, as well as reduced vacancy rates of 0.6 per cent, have significantly impacted on people who may be unemployed or underemployed or whose circumstances have changed. We are certainly seeing more people on the social housing waiting lists and more people pushed into homelessness—all of which is contributing to greater social isolation within the community.

Ms Vidafar: I would like to thank you for allowing us to put in a submission. I feel very strongly about this submission because, having worked in the homelessness sector and now working for a community housing organisation, I have seen the needs of our community and why we exist. I think we are all here because we are all passionate about solving this problem around loneliness and social isolation, and we know that it is a growing problem.

Homelessness is a growing need in our community and a community housing provider like us exists to meet that need, but there is a growing homeless population. From our point of view, people who are homeless have significant barriers. They include domestic and family violence, loss of employment, family and relationship breakdown, poor physical and mental health—health is a significant part of social isolation and loneliness—and lack of meaningful interactions.

As mentioned earlier, we are the largest housing provider in the Far North. A lot of people come to us from the cape and communities in order to access some of those services that we spoke about—health services, education services, housing—and to access different services. They move here and are very isolated because they have had to move from their community and from where their family and their cultural connection is.

When we think about social housing and the housing that exists in Cairns—and that is why we exist—we have a lot of properties that we currently manage that are one-bedroom properties. That already creates some social exclusion for people. Some of the things that we put in our submission were around: if we are building one-bedroom properties, how can we create meaningful connections for people? How do we create an area where people can connect and come together and get to know each other? How do we create connections with people and allow opportunity for community engagement officers or community connectors and for cultural advisers, for people to come together and help people connect with meaningful connections? If the reasons someone became homeless are, like we spoke about, domestic and family violence or health issues, how do we address that so that people are not excluded and start building those relationships with their networks and with those services?

Some of the other reasons I wanted to mention relate to young people. We have a lot of young people who exit state care and they, on a day-to-day basis, are becoming homeless as well. They are feeling socially excluded from a lot of services as well and do not have access to housing and a lot of mainstream services. People exiting prisons who are moving back to Cairns sometimes cannot return to their community for different reasons. Again, that can create social exclusion as well. As mentioned by a couple of people earlier around seniors, we have a growing older population. One of the stats that I found is that one in four seniors live alone, and we know that one in five people experiences mental health issues at any point of their life. How do we create that cohesion within those complexes for our older population as well?

Another interesting stat that I wanted to mention is that 67 per cent of the people who live in Australia are from a CALD background. I myself was born overseas. For people having moved here from their own country or for First Nations people moving from communities and from the islands, having to relocate for different reasons to be able to access services: how do we provide opportunities for them to connect back in?

CHAIR: Jessica, thank you. Both you and Elizabeth raised some really interesting points. The points you raised around children exiting care and the age that they exited and then the support required or the support provided is a point that has been raised during the inquiry and certainly is of interest in relation to age 18. In other states the age is a little bit older than that. You raised some really interesting points. Thank you.

Mr MANDER: Jessica and Elizabeth, thank you for the work that you are doing. You make a really good point about the one-bedroom unit issues. The department's policy basically is, 'Let's get single people, where their families have moved on, out of houses so they can be better utilised,' but we do not solve any problems if they are lonely in a house and then we put them in a unit and they are lonely in a unit. The point you made is very valid. Have you seen any models of that engagement where people are in some sort of complex or some sort of housing situation where the interaction and engagement is really encouraged and facilitated? Are there models around?

Ms Vidafar: I have seen a couple. One of the things that we have investigated is different culturally inclusive housing models that allow larger families, including CALD and First Nations families, to live together. One of the things we have seen is that there are communities, not necessarily here, that create opportunities for houses to be built and then a shared space for families to be able to come together and connect. I would love to see social housing and other housing providers take those learnings and for us to build different models that meet the needs of our community—an opportunity for people to have larger homes and allow different generations of people to live together rather than expecting that, once they reach a certain age, people have to move out, or having eligibility criteria around how many people are allowed to live in a three-bedroom home or in one bedroom together.

Ms Brown: The other thing, too, is around the design of the build to ensure there is built space for people to come together, so if you build an apartment building there is intentionally space created that has amenities to encourage people to get together. Also, be very intentional about the support services that are put around people to make them successful in their tenancies. That is not just a person in isolation; that it is looking at a community.

Ms LUI: Thank you, Jessica and Elizabeth. A couple of weeks ago we heard from a doctor in the UK talking about the thriving communities concept and what they are doing in the UK in bringing services together. Going off what you were talking about, Jessica, with the diverse and complex nature of your work and working with vulnerable clients around domestic violence and a whole list of other issues that they all face, what are your thoughts around thriving communities in increasing social enterprise capacity and those critical partnerships that we need in community to work more collaboratively as a way to move forward?

Ms Vidafar: I think we should explore and learn from anything that is happening in other countries. We need to have a place based response, but we need to include the people who are our clients and the people we are supporting to be a part of that conversation. I think a lot of the people who are in this room are service providers and people who are decision-makers, but how do we include our clients or our customers or our tenants to be a part of that conversation? They are going through that journey; they have experienced it. We need to understand how to include them in the conversations so that whatever we develop meets their needs.

Ms Brown: The other thing is around ensuring that the services are integrated, that there are strong partnerships between service providers. Certainly from a government perspective, there is very much still a fragmentation between different types of service, depending on which department you might be funded by. That creates divisions between support services. To truly be person centred in our approach, we need to break down some of those barriers and the fragmentations that exist in services.

CHAIR: Elizabeth, we have heard a lot of discussion with a range of communities around the service providers operating in silos—operating as you mentioned, in fragmentation and in isolation. How do we overcome that when we have so many service providers under a range of federal and state government funding? How do we coordinate that context?

Ms Brown: That is a really good question. We have seen over the last 18 months how we can come together as a sector. We have certainly seen that in Cairns as well as nationally and globally. Agencies, sectors and different organisations have been forced to work collaboratively around

meeting people's needs. There are a lot of lessons for us to learn out of that in terms of what we can take forward and how we can go about it. From a government perspective, look at where there is opportunity to have different governance over different programs and perhaps look at where there are connections in funding, for example between domestic violence services, housing, mental health, child and family services—all sitting under different government streams, often with small amounts or pockets of money for different brokerage services or different parts. There is a real opportunity to look at how we better utilise those resources by working across agencies.

Mr BERKMAN: Elizabeth, you mentioned in your opening statement the ongoing growth in the number of people on the social housing waiting list or register. My understanding of the data is that, over the last two years in particular, that growth has been almost exclusively people in the very high needs category. Is that your experience? Can you shed any light for us on why that is—what is driving the data in that direction?

Ms Brown: Yes, that is absolutely the case. We are certainly seeing more people with highly complex needs. I think that reflects increasing levels of mental health issues in the community, increasing issues with domestic and family violence—and the data supports that—and increasing issues with alcohol and other drugs. The combination of all of those complexities together is absolutely driving that degree of high need.

Ms Vidafar: We are in a space where there are a lot of people who would not normally have seen themselves at risk of homelessness. We have service providers who have employees who are at risk of homelessness and are struggling to find accommodation. We have stretched ourselves so that there are really only three products that we currently provide people who need housing: social housing, private rental or home ownership. A lot of our clients would not necessarily be able to move into home ownership and are struggling to compete in the current market to get into the private rental market. They cannot access that at the moment so the only option for them is social housing.

To be eligible for social housing, we have certain criteria. If you cannot get a private rental, you have to find a way to meet the eligibility to become a social housing client. If you do not have those areas that I mentioned earlier around significant financial issues or poor physical or mental health, then if you are homeless for a period of time you are going to develop some form of mental health problem at any given time. If you are homeless, you would have lost contact with a lot of your family and friends at some point. The issue is that we are going to see an increasing need for social housing. What I would love to see in the future is that we have different products to meet that need so that social housing is not the only product that people can access if they have significant needs.

CHAIR: Thank you, Jessica. Our time has come to an end. Thank you both sincerely for giving up your valuable time this morning. The committee really appreciates your contribution.

ASHTON, Ms Tracey, Social Worker, Cairns Community Legal Centre

CHAIR: Welcome. I imagine you are a very busy person, so thank you sincerely for giving up your time to spend time with our committee today. I will get you to tell us a little bit about your centre and what you do and then our committee will have some questions.

Ms Ashton: On behalf of myself and the Cairns Community Legal Centre, I thank you for the invitation to speak at today's public hearing. I would like to acknowledge the traditional custodians of the land, elders both past and present. I also extend my respect to other Indigenous Australians who are within this region.

The Cairns Community Legal Centre provides a number of services including a specialist seniors legal and support service. This service includes the provision of both legal and social work support within the areas of elder abuse and financial exploitation of older persons. The work undertaken through the Seniors Legal and Support Service involves legal advice, social work assistance, information and referrals, casework and community education. I am a social worker within that program.

Our submission to the inquiry into social isolation and loneliness in Queensland aimed to provide a unique perspective to the Community Support and Services Committee. This is achieved by focusing on older people in Far North Queensland, the demographic of the Seniors Legal and Support Service. To achieve our objective we linked known causes of social isolation and loneliness to the work that we do every day, considering that older people we meet are victims of elder abuse and financial exploitation.

The intersection between isolation, loneliness and elder abuse is extremely complex. Isolation and loneliness may result from being abused, but it may also be a precursor. Social abuse is just one type of abuse. A perpetrator may block contact with other people, family or neighbours or to technologies such as a person's mobile phone. While we think about the construct of family and that a lot of older people do not have a lot of family, the breakdown of relationships during abuse—and if it is ever addressed—may mean that the victim is left with no family contact. We also see the impact of abuse, mental health issues, depression and anxiety which can perpetuate isolation and loneliness.

We then looked at formal support service offerings to older people—the design and how gaps in service delivery impact older people. Being socially isolated and trying to navigate the aged-care system raises a plethora of issues. When services such as transport and social support are being sought, it can hinder a person's enthusiasm to access such services. We did note that the upcoming remodelling of the aged-care system will be an opportunity to address these issues and mitigate the risk of isolation and loneliness as a result. The centre supports the need for continued funding in many areas—mental health, housing, carer programs, counselling, mediation, community support centres and, of course, domestic violence and elder abuse.

Mr MANDER: Thank you for the work that you do. Elder abuse is such a scourge on our society. Do you have any insights into how we can protect older people from this type of abuse, which I assume is incredibly challenging when it is coming from sons and daughters and people who are obviously related?

Ms Ashton: I have a couple of ideas. I honestly think that at a systemic level, at a societal level, it is about the ageist attitudes that older people are faced with every day. That can be attitudes from their family, resulting in inheritance impatience and that kind of thing, where family members are thinking they are entitled to assets before the older person is entering aged care or has even passed away. That is something that we see quite frequently. Anything we can do to get the conversation started about the value of older people and the role they can play in society—that value is often overlooked—is always a good thing. I think that can start with community education. At the centre we are in that space now. Obviously that took a hit during COVID, but it is something that the centre is extremely passionate about. We are looking at different ways to reach people, change attitudes and get people thinking about what elder abuse is in its most severe forms but also in its most subtle forms.

Another thing we see a lot at the centre is that commonly a person has been appointed under an enduring power of attorney to make decisions for that older person. We would say that what it means to be an appropriate and effective enduring power of attorney is misunderstood. We think there needs to be some way to increase that understanding to ensure that powers of attorney are not operating when they are not effective.

Mr MANDER: That is a really valid point. I did it recently with my mum. I filled out a form, basically stuck it under her eyes and said, 'Just sign this, Mum. This is to look after you.' Luckily she has a loving son, but you are right: there is nothing really not only to educate but also to make sure it is valid and the older person understands what they are doing. It is a very valid point.

Mr SKELTON: Your submission highlights community care finder. Is that similar to what we were talking about with link workers and so forth? Is it a contact point for individuals to access services?

Ms Ashton: My understanding from reading the final report of the royal commission was that there will be funding for 500 care finders to assist people to navigate the aged-care system. I believe that funding is rolling out around 2023. I have spoken with the Council of the Ageing in our local area. I am not too sure how it is going to happen, obviously. It is not something that we will be involved with. I believe the primary health networks will be distributing that funding. I honestly believe that the aged-care system and the complexities—from time of assessment to actually getting services in place—are difficult for everybody, let alone if you have issues with digital literacy, if you are homeless or if you do not have access to a printer, a scanner, a computer and all of those things. I think people who are more vulnerable or perhaps more disadvantaged will benefit considerably from having somebody to actually explain that role to them.

The Council of the Ageing is extending its aged-care navigator trial in this area. It recently appointed what it is calling an aged-care navigator. That is a step in the right direction. There will be somebody based here in Cairns. The issue is that if you call the major care call centre you are speaking to somebody down in Robina on the Gold Coast. They do not have a lot of knowledge of where Cairns is, how geographically spread we are or what service offerings are available. It changes so frequently as well. There is different funding. One day a service provider might be available to provide lawn care and the next day they are not and they drop off the portal. I really think on a local level we need people with their finger on the pulse to provide support to people, maybe not to a level of case management and care coordination, although I think in some cases that is probably needed to see people get the result of having services put in place. Any assistance that is available on a local level in Far North Queensland is a move in the direction.

CHAIR: It was in Mount Isa that one of your colleague professionals raised the issue of ageism and the ageist discourse that is prevalent in our communities across Queensland. Certainly, it is something for our committee to think about in terms of ageist discourse being a significant contributor to social isolation and loneliness. Thank you for your contribution and thanks for giving up your time today. We really appreciate your valued expertise.

JOHNSON, Major Ben, Salvation Army

CHAIR: Welcome. Ben, I know that you have a contribution to make to this very important issue. I will ask you to take a couple of minutes to talk with us.

Major Johnson: My gratitude to all of you for allowing me this opportunity. The Salvation Army has made a submission. I was part of that process of doing analysis across the state and I was interviewed as part of that process. In Cairns we have one of the largest housing support services in the Cairns Supported Accommodation Services on Sheridan Street. My wife, Major Emma, runs that facility. We also have financial counsellors onsite here. We also run an alcohol and other drugs program from here. It also delivers services in Lotus Glen. We have our op shops and our volunteers who access those spaces and also the emergency services, as you saw on the other side of our property this morning.

I am also president of the combined churches network in Cairns. I wanted to highlight two things. First, the churches are very under-utilised in community development projects. I guess it is an awareness thing for the churches, but also I guess we are not thought of so much. I sit in two camps, as a community services organisation as well. Much of the way that chaplaincy in schools has been a really powerful way of breaking down some of those issues we have seen in our state schools and our private schools, there is opportunity for a similar kind of approach that is drawing on that support from the churches.

I also think local council is under-utilised. With the pandemic and the way things changed very quickly in that space, I am sure that local council has some extra funding to coordinate those efforts. They did bring the services together in a way that we have not seen before. Council did an excellent job in Cairns and continues to do that. I think we should do anything we can to strengthen those networks. We are looking for a parent body to look at how that is analysed across our community. I think that is a really powerful way of that being done.

CHAIR: Thank you, Major Ben. I am so glad we made some time for you. You raise some really valuable propositions and suggestions. Thank you sincerely for that. That concludes our hearing here in Cairns. On behalf of the committee, I thank all of the witnesses and stakeholders who have participated today. I also take this opportunity to thank the many submitters who have engaged with this inquiry to date. I thank our Hansard reporter, Bonnie, for spending her time with us, carrying out this very important function. A transcript of these proceedings will be available on the committee's parliamentary webpage in due course. I declare this public hearing closed.

The committee adjourned at 11.57 am.