MENTAL HEALTH SELECT COMMITTEE

Members present:
Mr JP Kelly MP—Chair
Ms AJ Camm MP
Ms AB King MP
Mrs MF McMahon MP
Mr R Molhoek MP
Mr BL O'Rourke MP
Dr CAC Rowan MP

Visiting Member:
Mr A Tantari MP

Staff present:
Dr A Beem—Acting Committee Secretary

PUBLIC HEARING—INQUIRY INTO THE OPPORTUNITIES TO IMPROVE MENTAL HEALTH OUTCOMES FOR QUEENSLANDERS

TRANSCRIPT OF PROCEEDINGS

TUESDAY, 8 MARCH 2022

Hervey Bay

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The committee met at 1.32 pm.

CHAIR: Good afternoon. I now declare open this public hearing of the Mental Health Select Committee. 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. 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. I would also like to acknowledge people with lived experience of mental health, alcohol, other drug issues and suicide.

I would like to introduce the members of the committee. I am Joe Kelly, the member for Greenslopes and chair of the committee; Mr Rob Molhoek is the member for Southport and deputy chair; Dr Christian Rowan is the member for Moggill; Ms Ali King is the member for Pumicestone; Mrs Melissa McMahon is the member for Macalister; Ms Amanda Camm is the member for Whitsunday; and Mr Barry O'Rourke is the member for Rockhampton. I am very pleased to say that this afternoon our committee has been joined by Mr Adrian Tantari, the member for Hervey Bay. Thank you for welcoming us to your electorate.

The purpose of today's hearing in Hervey Bay is to assist the committee with its inquiries into the opportunities to improve mental health outcomes for Queenslanders. This hearing is a proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. Only the committee and invited witnesses may participate in the proceedings. Witnesses are not required to give evidence under oath or affirmation; however, I remind witnesses that intentionally misleading the committee is a serious offence. I also remind members of the public that they may be excluded from the hearing at the discretion of the committee.

These proceedings are being recorded. Media may be present and are subject to the committee's media rules and the chair's direction at all times. You may be filmed or photographed during the proceedings and images may also appear on our parliamentary website or social media pages. Please turn off your mobile phones or switch them to silent. If any witnesses have any documents to provide to the committee, please ask to table the documentation while you are speaking. If you have any information you wish to provide to the committee following the hearing, please write to the committee and the committee will then consider your correspondence.

STEVENSON, Ms Tanya, Chief Executive Officer, Hervey Bay Neighbourhood Centre

CHAIR: We invite you to make a brief opening statement and then we will go to the committee to ask you some questions.

Ms Stevenson: That sounds great. I look after the Hervey Bay Neighbourhood Centre and I also sit on the management committee for Neighbourhood Centres Queensland. There are 140 neighbourhood centres across the state. We like to say we have social infrastructure as a community base that we provide multiple services out of.

In Hervey Bay, we deliver across the Wide Bay-Burnett. For the past three years we have been working on developing a neighbourhood collective framework based on the Safe Spaces model. We believe that everyone should have a safe space in the community: you should have your home, your workplace and then a social space. Unfortunately for our community, we are one of the most disadvantaged in our region and sometimes home is not safe and the workplace is non-existent for some of our more disadvantaged community members. The neighbourhood centre, along with many other support services, have developed community hubs.

We have our neighbourhood centre up in Pialba in which we have about 30 different services as a one-stop shop to deliver support services from. That includes some services from the neighbourhood centre. We do children, family and youth; legal and professional services; tenancy advice; multicultural services; transport; disability and aged-care services. We have a little bit in every sector but very much in the early intervention and prevention space.

Last year we partnered with Fraser Coast Mates and Bradnam's Windows to develop a youth space. We acknowledged that the community centre was not the right space for young people to come. We were lucky enough that a local business gave us quite a large industrial shed in the centre

of town. We spent six months as a community overhauling that space into a learning and innovation hub. We now have a dozen other services working from that space to provide that safe space for young people. Thank you to Adrian Tantari for donations to help us get that centre up and running.

Next month we will be opening officially our new Urangan community centre, which is based at the other end of town. It will have a focus on wellness and health. Again, it is another community hub from which we will not be delivering all of the services but creating that one-stop shop for co-collaboration of our services to be able to provide holistic and wraparound support services for clients, acknowledging that everyone needs some help. For some it will be early intervention but for others it will be quite significant. Not all of our services can provide the one-for-all but together we can develop that wraparound support to help them thrive in our community.

CHAIR: Tanya, you said that a lot of your programs focus on early intervention. Can you step us through that? Is that a clinical approach or is it another model of delivering services?

Ms Stevenson: Depending on what government funding we have—because we have about 30 different services. We have 65 staff and 350 volunteers who develop and implement our services. Our most intensive is an intensive family support service, which is your child protection services. They are clinical. For the majority of our clients, while child protection is the initial priority, the underlying issues for many of our families who enter that are mental health issues that are diagnosed and some undiagnosed.

CHAIR: Do any of your programs operate in the area of increasing family resilience or parenting skills?

Ms Stevenson: Yes, very much so. A lot of our speciality youth services are focused on developing resilience. Even with our child protection services we have worked with two other local organisations, CQID and the Wide Bay Women's Health Service, to develop women's retreats, men's retreats and then family camps where we are creating those atmospheres where they get to have real-life experience away from drug and alcohol and other issues. They do get to work through some of those healing frameworks that are delivered by specialists. The majority of our staff are not clinicians but they are in that secondary support service and beyond.

In terms of our Reconnect Youth Centre, which focuses on housing, we have seen quite an increase in the child abusing the parents and then having the parents wanting to relinquish. That has been a significant increase and stress to our staff. In terms of our social enterprise, which we have been now successfully delivering to focus on giving our young people who are homeless somewhere to start learning employment, our intake last week for that cohort involved 70 per cent of them having mental health issues, which is a barrier for them to be able to get support.

We do an annual youth survey in partnership with all of the high schools, and that is very sad unfortunately. Our increase at the moment around homelessness is that 15 per cent of our youth are reporting they have experienced homelessness in the last year. Some 16 per cent report that they are not safe at home, and 19 per cent are running away from home. One in three are actually accessing mental health services, with 75 per cent of them saying that anxiety is their main issue. We did see a decrease in alcohol use, but not very much, and that was increased with drugs unfortunately. Upon talking to the young people about why that was happening, it was basically that drugs are cheaper than alcohol.

Mr TANTARI: Tanya, you have given us some statistics around the individual cohorts that you deal with, particularly in the mental health space. From your own experience in Hervey Bay, what would you say is the most needy cohort of individuals who need that assistance in the mental health space?

Ms Stevenson: I would definitely say youth. I also sit on the committee for one of the local high schools. Trying to get services into schools to be able to access the young people who are dropping out is quite difficult. We do know notice there is a big gap between the 10- to 14-year-old group. Most of our services in youth focus on 14 to 18 or up to 21. We are seeing younger cohorts really starting to struggle with the lack of services available for them.

Locally we partner with all of the psychologists and counsellors where possible but, unfortunately, their books are closed at the moment. We do have wonderful grassroots services like Fraser Coast Mates and Red Bike Adventures Inc. that raise money for us to be able to pay for those counselling services where they are not accessible financially for our clients. We run the seniors legal service. With the elderly people, we do have quite a disconnect between mental health and dementia. That has become quite apparent in our legal services in demands around getting a diagnosis of mental health once they are over 65. It is very difficult. It is much easier to put it down to dementia, unfortunately, and then the supports are quite different.

Ms CAMM: Tanya, I hear great things about your service actually, more broadly.

Ms Stevenson: Thank you.

Ms CAMM: I am in the Whitsundays, but we have a great neighbourhood hub in Mackay as well. My question is really to expand upon that demand in youth services and, in particular, that cohort where you are seeing an increase in anxiety. You have answered my question about referral pathways, which is that they are very limited based upon access and demand. Is any work being done either within your service or with other collaborators to understand why? Why are young people aged 10 to 14 years seeing an increase in anxiety? Is there also any engagement with the families around that? Through your discussions with schools and other stakeholders, what do you see as the contributing factors of that in mental health?

Ms Stevenson: We have a really close partnership with one of the local primary schools, which funds us to provide a social worker into their high school. We have been piloting that for two years. Unfortunately, they ran out of their funding. They funded us themselves for the last year, but they just have not been able to do that again. That was, again, a holistic approach about working with family, doing early intervention and delivering one-on-one case management with those families in the school and outside of the school, because we have so much more flexibility than what Education Queensland can provide.

We did have the pleasure of having Dr Michael Carr-Gregg come up to our site, probably 18 months ago, and he delivered really great training to our sector around young people and the issues that they are facing. I think correctly, hopefully, he mentioned that the Mission Australia Youth Survey for the last 10 years has had stress as the most significant factor impacting young people. But when they did their research around the world, the actual issue was drilling down into problem solving and it was the fact that our young people actually have not been given the problem-solving framework to be able to work through their emotions. Instead of stopping and thinking about, 'Here is my problem, what is my option, these are the outcomes depending on what option I choose, how did it go?' and then reflecting on that, they are very impulsive still and they are choosing to either run away or fight their instincts. That is something that we have embedded in a lot of our programs: developing problem-solving frameworks and skills with young people, to develop resilience.

Mrs McMAHON: Thank you very much for the work that you are doing in the neighbourhood centres. I sit on the management committee of my local neighbourhood centre. There are so many different services that you are running. I imagine the various different funding streams coming from multiple different government departments requires a level of governance that is often beyond volunteers in many respects.

Ms Stevenson: Absolutely.

Mrs McMAHON: Could you tell us, and if you do not have the data off the top of your head that is fine, how many different state government departments are funding these services, both state and federal as well as local? So many people are trying to do the same things but often you are restricted because the different buckets of money have different outcomes and KPIs.

Ms Stevenson: Absolutely, yes. At the moment we receive funding from the Department of Education, which is a Play With Your Kids program, so aimed at the zero to eight-year-olds. We have Department of Communities funding, which is Bay Families, which is a secondary support service. Then obviously there is the Intensive Family Support Service on top of that. We then have the Department of Health, the Department of Ageing and the Department of Social Services. There are, I think, about eight different funding bodies that we have to work with.

We do thankfully find that we do not have much crossover. Where services are limited we have been successful with the Department of Social Services giving us funding for community navigators. Where we have crossover or we have specialist services like our tenancy advice, our legal services and our youth homelessness services, we are seeing a large backup and waiting list. Those specialised workers were getting caught up doing follow-up paperwork transporting them to another service they needed to get. The community navigators now look after that part so we have been able to stop any crossover by using those particular services as a pilot to help with that.

Mrs McMAHON: Would I be right in saying they are almost like a case manager?

Ms Stevenson: Yes, short term.

Mrs McMAHON: Rather than the different programs being siloed, they are being case managed. They might be identified across a number of different programs, but in attending that one program they find there are many other touchstones through there.

Ms Stevenson: Yes.

Mrs McMAHON: For the navigator program, where does the funding for that come from? Is there a particular bucket of money?

Ms Stevenson: It is the cashless debit card.

Mrs McMAHON: But that still has to come from somewhere.

Ms Stevenson: Yes, the Department of Social Services under the Strong and Resilient Communities—SaRC, I think they call it.

Dr ROWAN: Thank you, Ms Stevenson, to you and all of your staff at the Hervey Bay Neighbourhood Centre for all the work that you do. My question is really around the alcohol and other drug programs that you run. I would like a bit more information about that. A little earlier you mentioned there had been a reduction in alcohol usage but an increase in usage of other substances amongst young people. Is that cannabis or amphetamines or what are you seeing in that space?

Ms Stevenson: We have 22 per cent of young people saying that they drink alcohol, 78 per cent saying that they are drinking excessively and then 10 per cent using drugs. We get funding from the Alcohol and Drug Foundation and have worked with the Rural Doctors Clinic with UQ—I think that is their title—to develop a youth first-aid program, which is specific to drug and alcohol impacts. In collaboration with Queensland Health we acknowledged there was a significant number of our young people entering ICU because they were not getting help as quickly as they could. Yes, some of the impacts from that and what we are seeing the young people choose, as their coping mechanism of choice really, has been impacted through our 'local entrepreneurs' during COVID when drugs were not as readily available. We had a number of locals deciding that they could make their own and that then impacted the ICU numbers at the hospital.

Dr ROWAN: Is there more that can be done in that space? Have you got any specific recommendations for the region as to what could be additionally done to assist with dealing with alcohol and other drug issues amongst young people?

Ms Stevenson: I was talking to our youth workers only this week and our biggest issue at the moment is transport for young people. We spend a lot of brokerage money in trying to engage young people into sport and other community activities. While we get the funding to be able to pay for some new soccer boots and registration, to get them to training at night and on the weekends there is just nothing. Allowing youth workers to work outside of hours and providing funding for overtime or whatever that needs to be to get them there would be one of the key outcomes for us. It is more flexibility in the service delivery times to support them to engage in greater community activities.

Just yesterday we had a 12-year-old released from juvenile detention, which happened on a Saturday. That was a pain in the neck for us, honestly, because we had no way of getting the youth worker who was engaged with them to try to support the family for re-engagement. She had been down there for six weeks—two weeks over what she should have been because of COVID outbreaks and floods. Then she basically went straight back to her cohort and the break and enters and all of the unfortunate things that they are involved in because they do not have anything else going on for them.

Mr O'ROURKE: Firstly, thank you to you and all your staff for the wonderful work that you do in the community in supporting particularly our young people. What is the age group that you are talking about in that space?

Ms Stevenson: For us really we look from 10 to 25. That 10 to 14 year age group is really where there is a huge gap in services and availability for your early intervention. We do work quite closely with that 14 to 18 cohort because of the Reconnect service, which is Department of Social Services funded. It is specific to homelessness so if they are at risk of homelessness. At the moment I think the whole of Queensland is struggling with the housing crisis, but we always had one of the highest rental vulnerability indexes here and that has impacted our housing much quicker. Unfortunately, with the financial strain for those families, we are seeing young people having to double up with families. Cohabitation with other families is creating more domestic violence issues for us. A lot of the families are then looking at relinquishing their teenagers, which is not really an option at the moment because there is nowhere to house them.

Mr O'ROURKE: Does your organisation actually have any youth housing?

Ms Stevenson: No, we do not do housing. We work very closely with Regional Housing Limited and CHL to provide housing for the young people.

Mr O'ROURKE: It is still a challenge, isn't it, that 10 to 14 age group regardless, because you cannot get them into youth housing because of the age group.

Ms Stevenson: No, absolutely not.

CHAIR: You talked about the new centre you are opening at Urangan, which is going to have a focus on wellness. One of the things the committee has heard frequently is the issues around people being diagnosed by a GP and then really not getting any further services until they are basically unwell enough to be hospitalised. Do you feel that a service like the one that you are anticipating at Urangan can play a role in terms of responding to that missing part of the system?

Ms Stevenson: We are hoping so. We heard, and it was just anecdotal statistics from Queensland Health, that we were seeing three times the amount of people presenting to the ED for mental health issues. We are hoping that providing a safer and less clinical space for people to be able to come and get support will be helpful. We do not obviously provide mental health services, but we are collaborating with local psychologists, Queensland Health and other OTs, and some other legal services as well, to provide that holistic support from that centre as a one-stop shop. We will provide everything from morning tea to come and play board games, right through to then seeing a nurse on site for your cancer care follow-up and that kind of thing.

CHAIR: You said the psychologists in this region have closed their books.

Ms Stevenson: Yes, unfortunately that has been one of our biggest issues. We are working with May, the head of the psychologists here. She is looking at establishing a clinic down at the Urangan centre to be able to train more local psychologists. At the moment that is one of our backups and it is putting stress on our staff: that we have delivered our service, but we cannot hand them over because they have significant mental health issues. The psychologists have at least six-month to 12-month waiting lists or they have closed their books and so then we look for counselling services, but unfortunately they are not subsidised. A lot of our clients cannot afford the fee that that costs.

We are again lucky to have local groups like Fraser Coast Mates and Red Bike Adventures. They raised $20,000 for us last year and that $20,000 literally just goes to paying local counsellors to be able to provide counselling services to those who cannot afford it. It is usually a lot of younger people that are accessing those services. Again they only get their 10 free sessions. The benefit of some of our centres is that there is no limit on how many times you can come to our services.

Mr MOLHOEK: Thank you for being here today and thank you for the great work that you do. At the start of your presentation you said there were 139 neighbourhood centres.

Ms Stevenson: Yes, over 140, I believe now, neighbourhood and community centres.

Mr MOLHOEK: The local one is, I assume, not-for-profit. It is completely community based.

Ms Stevenson: Yes, that is it.

Mr MOLHOEK: Can you reflect on what has changed since the NDIS has come into effect? Has that had an impact on your funding and your ability to deliver services or are you actually picking up clients who pay for services now? How is that working for you?

Ms Stevenson: We do not deliver NDIS services. There are plenty of other really good organisations that do that, which we partner with. The impact for us has been very minimal. Because we were not in that space we did not lose any services. We do have the QCSS and the CHSP funding, which is the in-between—trying to hold people until they can get their packages sorted. I do know that through our local disability alliance our region has one of the highest bank accounts of funds sitting there being underutilised because they cannot access services. Whether it is an OT, a speechie or anything, there really is that lack of skills in our area to be able to access them early. For us the impact has been minimal because it is not a huge space that we are in.

Mr MOLHOEK: I have visited some other neighbourhood centres and it would have been lovely to have visited yours while we were here, but we have been unable to. When it comes to the layout, are there drop-in areas and meeting rooms and play groups?

Ms Stevenson: I think we are very lucky: with foresight, the state government 10 years ago built us an amazing centre. It is huge. I think we have probably one of the nicest neighbourhood centres in Queensland. We are very lucky to have that premises. It has a hall that houses up to 200 people, plus a dozen meeting rooms and boardrooms, and then 20 other office spaces where we have our services, but also many other services that live with us and co-locate and share services and spaces. I think 60 other user groups also use that neighbourhood centre. Everybody from the bird club and the plant club to the book club meets at that site. It is pretty much open from 6 am in the morning until 10 o'clock at night and people are using that space.

Mr MOLHOEK: Is that completely independent or is council the landlord?

Ms Stevenson: Yes, council is the landlord and we pay $1 peppercorn rent, but we do all the maintenance.

Mr MOLHOEK: And you manage and run it?

Ms Stevenson: Yes.

Mr MOLHOEK: Fantastic.

Ms Stevenson: Yes, it is. It is really beautiful. I think if you could have a centre like that in every town it would be amazing, because you have that opportunity in the space to be able to deliver anything the community wants and at an affordable price for your services as well.

CHAIR: Tanya, I want to thank you for presenting this afternoon. Your evidence here has been very useful and will very much inform the committee's report going forward and the recommendations we make to government. On behalf of the committee, I ask you to thank your volunteers and your staff for the work they have done over the last few years during COVID. It has obviously been a very difficult time. We do appreciate the work that people in your organisation have done, so thank you very much.

Ms Stevenson: Thank you.

BOSLEY, Mr Darren, President, Fraser Coast Mates

GRUMLEY, Mr Peter, Committee Member, Fraser Coast Mates

CHAIR: Before we start, I acknowledge the member for Maryborough, Mr Bruce Saunders, who has joined us. Welcome, Bruce. Thank you for your interest, Bruce. I welcome representatives from Fraser Coast Mates. You heard all of the opening statements, so I will not go through those again. We would appreciate it if you would give us a brief opening statement and then we will ask some questions.

Mr Bosley: I would like to acknowledge our local member, Adrian, who has been fantastic for our organisation in terms of support. We talked about this a while ago and we are really pleased it has all come to fruition. Fraser Coast Mates is an organisation that was formed six years ago through a tragedy. The tragedy was that there was a well-respected gentleman in the business and general community with a terrific family, and the next minute his closest mates, who did not know he had been struggling with a mental illness, learnt he had taken his life. A group of gentlemen came together in one of our beautiful seaside cafes called Aquavue. There were about eight gentlemen at the time who sat around asking questions. They said, 'So where do we go if we're struggling and who do we speak to? Does anybody know what the process is?' We had a lot of questions that I am sure everyone in the room has heard before, but it was an eye-opener for a lot of us who have not had any experience in mental health. Our voluntary group came together from that day.

Our organisation was formed with the goal of increasing awareness around mental health and ultimately reducing suicide in our community. I have heard the words 'early intervention'. We focus on early intervention. We do get approached many a time on posts and it is a little bit late for us unfortunately, but we are there to support families, which we have done. Probably through our experience that example is a common example in the community that we have heard before—that is, the stigma of men in particular who are afraid of speaking up, afraid of actually talking about their emotions, talking amongst their mates. That gathering of those gentlemen that morning was probably the first time I saw some men be quite emotional and quite open in their conversations.

Through our fundraising we are able to fund counselling, as Tanya mentioned, for urgent situations. One of the most common situations we get is a gentleman has gone to the doctor, the doctor said, 'Go home and take these pills and see how you feel.' He does not feel well; he comes back. He then gets a mental health plan but cannot get in, so he tears up the piece of paper and says, 'That's it. I'm giving up on it.' If we get that situation, we want to get them in front of a councillor within 48 hours. Over a period of nearly six years we have had over 150 people we have put through counselling services. We fund up to five services free of charge. If we get a phone call from those councillors that we use saying that a person needs more help, we put more funding that way. And we know that we have saved lives. We absolutely know that we have saved lives. We have clear examples of it.

Tanya talked about the partnerships that we have formed with Hervey Bay Neighbourhood Centre, and that is something that we feel very passionate about—that is, uniting the community. We worked very closely with Wide Bay health in particular very early and the statistic they gave us—and I can still remember the day they said it—was that 75 per cent of suicides do not speak to a professional service. What is really interesting is that six years later for every four people we give the phone number to of a counsellor only one of that four are making the phone call and making an appointment. We are conscious that there is a real issue of getting them on that bridge to recovery.

We have received fantastic support from the Fraser Coast Regional Council at the highest level. We were fortunate to get some funding from PHN for a social media campaign. We approached the CEO of the Fraser Coast council, Ken Diehm, to speak on behalf of the council. The morning he turned up he said, 'I don't want to talk about the council. I want to talk about my experience. I want to talk about what I went through many years ago and what I had to do to get through it.' I have to declare that I work in the digital marketing space and the click-through rate on that social media campaign was one of the highest I have ever experienced, obviously because people knew of him but his words were strong and that lived experience that has been mentioned plays a really key role.

I can show you this after the meeting, but another initiative which the council worked with us on is the *Little Black Book*. We printed 5,000 copies five years ago thinking that that would last us a couple of years, but we are just about to print our 20,000th copy. The *Little Black Book* is a reflection of our community, and this is the thing I probably want to reiterate in terms of what we focus on: every community is different. Every community has its strengths and weaknesses and their own make-up. But our voice, which we try to get across to everybody, is very tailored to this community. We think the popularity of this book has been based upon that because, yes, it has a list of services—it has a

list of counselling services and general health services—but it also lists Older Men Unlimited who do woodwork and it has swimming clubs. We had an example of a man who turned up after six weeks of living here who said, 'I found this book and I found out about your club and I've come along here.' He said, 'I'm actually struggling a bit too.'

In winding up before Peter has a quick word or two, I have worked in this community for 12 years in some senior media roles. I have to say that after working on a number of community projects mental health is the one that I see that makes small business stop in their tracks. It is the one issue that you can see on the small business owner who is struggling to put food on the table for his family and he is struggling himself or in terms of their deep care of their staff. We are completely funded by the business community and every time we have a fundraiser it just astounds us how deeply they put their hands in their pockets to help us out. We also have very good support from large organisations like Downer and CR Mining. Peter, do you want to say a quick word before we wind up?

Mr Grumley: Yes. One of the other things we have done—and I work with a guy called Dr Dan Banos, who is a psychiatrist—is some population health approaches to how we operate within the community. We developed a thing called the toolbox with a local psychologist and it is based on the whole R U OK? application. I have been really blessed that I got to all of the workers—that is, the average staff member. I got to all the outside staff of council, and it is a 15-minute or 20-minute talk, just to raise that awareness of R U OK? and looking after your workmate. With regard to CR Mining in Maryborough and EDI Downer, we have got to these folk and been able to talk to their base worker. It is a 15- or 20-minute talk. We volunteer to do it and I feel it is just population health promotion at its best. We have pulled some statistics around this. We get good help from Wide Bay health and I think our approach and how we are doing it is a gradual momentum throughout the community in that we are making this awareness grow and grow and grow. We very much work at the starting end of the continuum of health. We do not work when there is a diagnosis of mental health or mental illness; we are very much up the front end of keeping people well. Our ultimate goal is that not one family has to go through a single suicide in our community. Thank you.

CHAIR: In terms of your organisation, just for the benefit of the committee's understanding, do you have any paid staff or is this all done by volunteers?

Mr Bosley: It is a completely volunteer group.

CHAIR: So when people approach you with struggles and things of that nature, do you have the capacity to handle that internally or do you always refer people on?

Mr Bosley: We do. We are fortunate in that we have a couple of counsellors and we have agreements in place where we know that we can get someone in front of them within 72 hours.

CHAIR: You talked about small business. We heard from another gentleman yesterday around the pressures on small business and the impacts on mental health. Is your experience that it is the people who own and manage small businesses who are struggling from a mental health perspective or are they aware of issues for their staff or the community more broadly? What is your perspective there?

Mr Grumley: Both. It does not matter whether it is a person who is a worker within the organisation or a business owner; they are an individual so it is both. Recently with these floods and everything like that, it is impacting a whole lot of folk.

CHAIR: Yes. You obviously worked together to try to mobilise some counselling resources et cetera. One of the big challenges that we have heard about in this committee everywhere that we have been is around workforce issues. Has it been difficult for you to find counselling or psychology or even social work services to support people?

Mr Bosley: We were fortunate to find a company called Trauma Assist, which have been fantastic. We cannot question their service and their availability. More recently, and something that Tanya mentioned, there is a joint project with Red Bike Adventures where we both use Fraser Coast Counselling. We have an example where he goes out and visits sites. He has offered to go out to Maryborough and visit people out that way, and from a mobilisation stance that has been really helpful for us.

CHAIR: Finally, I am reflecting on the story you told about your formation in the local cafe. How powerful is it that you have people with similar life experiences talking to one another and trying to solve a problem like this?

Mr Bosley: I have never experienced anything like it in my life, and obviously personally it shook me because he was a close friend but then knowing that I was not alone in not knowing. One of the things we sort of discovered through this process is that people who suicide generally do hide

their plans. That group of eight were all very close to the gentleman in question who just hid it from us, so it has been quite therapeutic in some ways. Also, as Peter said, it has been quite strengthening as a group of people to make sure this does not happen again under our watch.

Mrs McMAHON: I just wanted to follow up from the chair with a quick question in relation to the workforce. Everyone we have spoken to has identified an issue with psychologists and that clinical aspect. You have made several references to 'counsellors' and the ability for those visits to be quite rapid. I was wondering if you could provide a comment on the role of counsellors versus the role of psychologists and whether at that first point of intervention—that is, getting that very quick response—it makes a difference whether a person is a fully qualified psychologist or whether someone who has some counselling accreditation can do the just-in-time management.

Mr Grumley: It is a triage. We are very fortunate to have the counsellors. In discussion with the counsellors—obviously not breaking privacy—it is often that a person will turn up and within the first or second session they know that they have to go to a more appropriate person and all that system starts to happen, so it is a triaged program. We are not qualified counsellors. We make sure the folk that we work with are suitably qualified and everything like that, but it acts as a triage.

Mrs McMAHON: I guess that was my question—that is, that the workforce that you are using in order to do that triage are qualified and registered counsellors?

Mr Grumley: Yes. No, we provide—

Mrs McMAHON: Yes, I understand. I know psychologists can counsel, but then the difference between the terminology of 'psychologist' versus 'counsellor'—they are two very different organisations.

Mr Bosley: We understand that and it is a constant discussion amongst our committee. The point I would probably add to that from our experience—and we are talking about over 150 people—is that particularly in men—we have become a lot more inclusive with women; in fact, six of our 11 committee are now women—once the conversation has begun and communication has happened with that counsellor that is when we know that person is on the road to recovery, so that to us is the big sign.

Mr Grumley: If I can give one quick example. We have referred people and they have gone to the counsellor. The counsellor may say, 'Go and do the swimming group on a Saturday morning with those fellows; you'll be okay,' or 'We need to get them in front of a psychiatrist,' with that real urgency. It is working out and finding out what is suitable.

Dr ROWAN: First of all, Darren and Peter, congratulations. You are a credit to your community for establishing Fraser Coast Mates out of adversity, together with all of your volunteers. The question I wanted to ask is about funding, because there seem to be two parts that you have there. You have the people you are supporting individually who might have stress and they have gone into crisis, whether that is related to financial or family or relationship, small business owners or workers. That is one part and you are obviously working with other agencies and groups to do that. However, I wanted to come back to the other part around the population health things that you have mentioned and the toolbox. What could be further done or what is needed from a financial support perspective to make those sorts of things—and it does not have to be from a particular level of government or any level of government—such as the toolbox that you mentioned and that population health assist with building resilience in the community?

Mr Grumley: It is interesting because I have done a lot of study in the area of public health and population health. Darren and I often discuss whether we would like to go to that next level, because at the moment there is myself and another good mate who is an Indigenous fellow. We have put an Indigenous slant on the toolbox as well, so Les helps us out with that. We are not too sure whether we will go to that next level because then we need a whole other form of volunteers who are trained appropriately and go from there. It is our next step that we are going to have to work our way through with the committee and see what response we get from the public, and I know it will be supported by Adrian and everything like that. We are not too sure because that is another leap again, and we have to do it properly with all of the evidence based material. It is all right to sit at 10 o'clock at night gathering that evidence based material to make sure it is right as a volunteer, but to do it again in a paid position—I am not sure.

Mr Bosley: I would also add that something we had to learn very early was we were surprised by the many organisations in the region. We always thought that we did not have enough. We know those organisations are probably overloaded, but we have been resourceful around it. This is where we have just made sure we have connected with people. We have had fantastic support from the Hervey Bay Neighbourhood Centre and then you find out about other organisations. I think one of the

issues—I got frustrated very early in this journey—is that there are hundreds of organisations out there but they do not know how to work with each other, yet they all have a common goal. We all have a common goal so let's just get a little bit closer. If we need some help in a particular area of service, we will go and find that organisation and get them to do it for us.

Mr TANTARI: Thank you, Darren, for coming along. It is really great to see you. I want to acknowledge the work that you do in this area. You were talking about some of the areas you are covering regarding the mental health space. Just out of interest, what has the impact of COVID been on your group, particularly since March 2020 when COVID became prominent, all the lockdowns started to happen and individuals were basically ostracised or in their homes locked up? Did you find an uptick in the requirement of your service?

Mr Bosley: That is probably the most common question our organisation receives in these types of forums and discussion points. I was really interested in reading the transcripts of previous meetings to see some of the statistics and things mentioned. There is no doubt after three or four months we saw a climb in contacts of people who are worried about business and associates and family and friends and that sort of thing; it is just very hard to equate what the actual final outcome of that is. I know I am not committing to any sort of result with that, but we just do not have any clear statistics around it. The thing we know in the space in particular that we work with is that, as I have mentioned before, people do not speak up. We have focused a lot of our attention, particularly in our communication in the last 12 months, around checking in—checking in on your mate, checking in to see how they are, asking the question. They may not speak up the first time, but they might speak up the second, third or fourth time. That is probably where we have really focused hard in the last 12 months.

Mr TANTARI: Thanks for that, Darren. I want to congratulate you on the *Little Black Book*. It is a great resource. It is absolutely great.

Mr Bosley: Thank you.

CHAIR: On that point, would you have a copy of the [*Little Black Book* with you today?

Mr Bosley: I do.

CHAIR: Could we get you to table that for the benefit of the committee?

Mr Bosley: Yes.

CHAIR: Thank you.

Mr MOLHOEK: I want to commend you as well on the work that you do. We have a branch of Mates on the Gold Coast as well and they catch up from time to time. My question is as much for the public record as for my own education: how does it actually work? Do you run social gatherings? Do you have information booths on construction sites? How do you actually run Mates so that you are engaging with people and meeting them?

Mr Grumley: I suppose the original eight guys had a network already going, because we are not a really big community and people come from various backgrounds. If I could just add something: Darren set up some fantastic social media stuff like Facebook—we constantly do that—and it is very localised. All of the photos are localised and everything like that and the website. We are good at running golf games. We have tennis games. We have all sorts of activities such as walks. I met our local member when I was trying to find the water spots going along Point Vernon for our walk on Christmas for his campaign. The way we do it is that actual true connection of the community in saying, 'You know someone, you know some other people,' and that is how it spreads and goes throughout the community. We still have to get there, but it is initially that network that has been created through our committee and then on and on. I belong to a couple of different groups and Darren belongs to a few other different groups and it all kind of collaborates together and comes together.

Mr MOLHOEK: So does it revolve around you conducting social activities or sporting events such as golf days and tennis? Is that the way you expand that network and those contacts and involve people?

Mr Grumley: Yes. Again, we are Fraser Coast: it is Maryborough and Hervey Bay, and I have been out to Burrum and done stuff. Apart from the activities, we have done some stuff at one organisation, for example, in Maryborough and they said, 'Have a talk to these guys,' and that is how that momentum builds.

Mr Bosley: We hold a number of events throughout the year such as a golf day, which has grown astronomically each year, and a tennis day. I want to mention that recently we connected with a new group that opened up here in Hervey Bay called the Man Walk, which is quite a popular

franchise around Australia. We approached them about funding a Monday night training session and making it open to the public. As of last night it has now had its third night—I was silly enough to attend—and we had 19 people turn up. We are hoping that will expand if that is what our funds can support to get people in. Last night I know there were four new people and I can see this really growing.

Mr MOLHOEK: What was last night's activity?

Mr Bosley: We paid for a personal trainer to come out and hold a public 45-minute fitness session. We made it open, as for all sessions; we made it open for men and women. Last night was the third one. We started with nine people and last night, as I said, we got to 19.

Mr MOLHOEK: So are you sore today?

Mr Bosley: Very; let's not go there!

Mr Grumley: That is the other thing. One thing we really encourage in the *Little Black Book* is that there are local activities for people to get involved in because, again, the psychosocial behaviour—

Mr MOLHOEK: So it is really about trying to get people more socially connected and in an environment where they can talk?

Mr Bosley: Yes, it is. I will quickly mention the Neighbourhood Hive that Tanya mentioned before. One of the reasons we were super keen on that is that, first of all, it gives people social interaction in training programs and, secondly, it is around a passion. There would be something in the session—whether it is photography or podcasting or something—that generated the passion and then that solves the issue around social interaction. We think that that is going to be a fantastic initiative.

Ms KING: Thank you, Darren and Peter. It has been fascinating to hear the approach that you are taking to addressing mental health challenges in your community. I want to ask you about stigma. The chair mentioned that we heard from a small business advocate yesterday, and I think I can paraphrase, who said that the quickest way to wreck a small business event is to make it about mental health. He was specifically commenting that in his view branding anything as being about mental health, particularly for the small business community, drove people away in their hundreds—that seemed to be his take. Yet you are engaging on mental health and mental wellbeing issues more broadly. It sounds like you are engaging quite directly with those issues such as suicide prevention. Could you tell us about your experience of stigma? Are people in the community prepared to engage with you whatever your branding and approach about mental health as your core business?

Mr Bosley: I think the point you raise is a really important one. We know that if we held an event for everyone to get in a room and talk about mental health we would not get too many turning up, so what we do is we get 200 people turning up at a golf day. I have a statistic: every year we get two people walking forward and saying, 'I need to see a counsellor. I didn't realise the way I was feeling is related to my mental health.' If that means we have to have a golf day once a month with 200 people—although we will not because it is too hard to raise—that is where it comes from. We were working on an annual dinner with a speaker to talk about it. It is interesting to note—and it was probably from a timing point of view—that we struggled to sell tickets. It is that thing of sport. It is that thing of physical activity that we talked about. It is really important to get people moving. After having conversations with people, if people know it is a social event then they will come along; if they know it is going to be someone standing over them asking about mental health, that is where it starts to get a little bit uncomfortable.

Ms KING: Yes, it is interesting. In some other areas that I have an interest in they talk about side-by-side activities as being protective of mental health and building relationships—I guess classically it would be doing a puzzle, but it might be playing a game of tennis. Everything you have described is pretty much a side-by-side activity, so that is interesting.

Mr Grumley: For example, at the golf game at every tee there is a little question like, 'How are you sleeping?' It is just that little prompt. We then ask everyone to, during the day, go to someone and say, 'How're you going? How're you travelling as far as your mental health is concerned?'

Mr Bosley: Two years ago we introduced a new thing where, when they finished their final hole, the group of nine people got a letter out that they had not seen and the letter said, 'Give one minute of what mental health means to you and the experience of it.' My experience over those two years of being involved with nine people at a time is that three will not speak—they are not comfortable with speaking; three will be really quite open and will talk about all sorts of things such as drug problems and all sorts of things; and then the other three have their eyes wide open saying, 'I never realised this' or 'I never realised that.' The breakdown is interesting.

CHAIR: I would like to thank you for presenting this afternoon. Your presentation here has been excellent. I have had a quick flick through the *Little Black Book* and I do like the way it is laid out. It is very good. On behalf of the committee, I would like you to thank all your volunteers for the work that they have done, particularly over the last couple of years during COVID. It is an interesting model that you are rolling out. It will certainly inform our report going forward. Thank you very much. I now welcome representatives from Flourish.

GIBBONS, Ms Debra, Regional Manager, Flourish

MATTHEWS, Mr Trevor, Regional Manager, Flourish

CHAIR: Thank you for coming to present this afternoon. I invite you to make a brief opening statement. Then we will go to the committee for some questions.

Mr Matthews: I will start by telling you who we are, what we do and where we come from. Flourish Australia has been around for 70 years now, in one form or another. We are the result of PRA New South Wales and New South Wales RFQ amalgamating about seven years ago. We are in New South Wales, Queensland and Victoria. We have been here in Queensland since 2010, and since 2011 in Hervey Bay specifically. We have Queensland Health funded services, mental health services as well as NDIS services across three sites—Hervey Bay, the Sunshine Coast and down in Caboolture. Today, we want to highlight the work that we are doing up here in Hervey Bay, particularly our Peer Operated Service in Hervey Bay.

After looking through the terms of reference, we would like to offer our experiences and our knowledge and we look forward to sharing that with the committee. The [Peer Operated Service has been operating since 2011. It is a model that is duplicated; there is another service down in Brisbane. As the term would suggest, it is a service that is operated by people who identify with a lived experience so the management of it is lived experience. It sits within the broader umbrella of Flourish Australia. Debra Gibbons, to my right, is the regional manager, team coordinator peer specialist. The operation of the day-to-day and what happens at the [Peer Operated Service is driven by the staff and the peers—the people accessing the service who have a lived experience. I would like to let Debra Gibbons speak on behalf of people with a lived experience and about the work that she does.

Ms Gibbons: I would like to speak more to the Peer Operated Service that is situated in Hervey Bay with Flourish Australia. Like Trevor shared, all the staff, including myself, are volunteers. We all have our own lived experience of mental health challenges. We provide four different programs: we provide one-to-one individual support; we provide group support; we provide a phone service which is called WarmLine; we also provide a rest-and-recovery home called Spinnaker. All aspects or facets of the groups and the day-to-day running of the service here locally is always done in consultation and co-design with the people who access the service. In regards to groups, they decide what groups they would like to do. If there is enough interest then we facilitate the operation of that group. They actually facilitate most of the groups themselves. The staff are just along to offer encouragement and to participate, as well. They will do up their own programs of 12 weeks of the different activities that they want to do for one specific group. That is how the groups are run. We have a Community Advisory Council, as well. That is also a co-design model and it has members from the different areas and regions where Flourish Australia services are provided.

CHAIR: Does your service have a geographical location of your service or do you just operate where you can find space?

Mr Matthews: Yes, there is a centre-based program called the Resource Centre here in Hervey Bay, which is predominantly where most of the services are provided. The WarmLine is operated from there as well as, on weekends and evenings, at the Spinnaker rest-and-rejuvenation property or respite property. It is located here at Hervey Bay.

CHAIR: Why do you call it the 'warm line'?

Ms Gibbons: I have been asked that just recently. I believe it is called the WarmLine because it is not actually a 24-hour hotline, as hotlines go. I also feel that we came to that name of 'WarmLine' because when you call the WarmLine you are talking to somebody else who can probably relate or who has had similar experiences. It is not about us judging straight away and going through that process of calling triple 0. It is about having the conversation with the person and being able to relate. It is a much warmer approach than some other hotlines might be. It is not a crisis line.

Mr Matthews: It is not a crisis line and that helps make the distinction.

CHAIR: Are the people who are engaging with you on that service people who you have a relationship with already for the most part or is it a mix of people?

Ms Gibbons: It is a mixture. There are people who have accessed the service for quite some time through the WarmLine or through the centre services, like groups or to use the rest-and-recovery house or one-to-one support. There are some people who ring the WarmLine from Bundaberg who we have never actually met but we have talked to on the phone for years. Then there are anonymous calls, as well. Although it is not a crisis line, people do call in emotional distress, experiencing suicidality and psychosis.

CHAIR: How do you manage that?

Ms Gibbons: The peer workers who answer the phone are trained in the Intentional Peer Support model. They also have training in certificate IV and mental health peer work. Our framework is from Intentional Peer Support, so it is about that connection and relating—not jumping in to fix something by calling triple 0, but to say, 'That must be a terrible place to be in. Have you experienced this before? What has worked for you before? I have experienced that myself before or similar,' and we go from there. We do have a duty of care and policies and procedures, but it is a conversation. It is not saying straight away, 'Do you have a plan?' It is about what is happening for the person in that space.

CHAIR: I want to ask a couple of questions about the rest-and-recovery home. How many beds are there? How long do people stay? What is the criteria for accessing space in that facility?

Mr Matthews: It is self-referral. We do work with the Wide Bay HHS, as well. It was set up originally to be self-referred. It is up to three weeks. We have noticed a significant drop-off in the usage of that property due to COVID. It has actually just been taken back by the HHS, which had a more pressing need for it. It is something we are no longer going to be doing for the rest of the contract that we have. People stay there to get away from, I guess, the issues they are facing at the time and to have little bit of extra support. It is another option for a step-up model, without it being officially 'step-up'. It is in that space where peers can provide support before that crisis gets to the point where they may need to access or be admitted to hospital.

CHAIR: Would you have statistics around hospital avoidance?

Mr Matthews: No, largely because the referrals that come through are self-referred.

Mrs McMAHON: There are two areas that I want to focus on and the first is the peer workforce. Today we have spoken to a couple of people within government about a peer workforce. You mentioned the certificate IV. What training or qualifications do you need for an organisation to say that they are peer led or they have a peer workforce? As you will have seen from our terms of reference, we are very interested in the role of people with lived experience in the workforce. Not everyone who has a lived experience is necessarily going to be a great peer worker. How do you find, identify and train? What are you looking for in that workforce?

Mr Matthews: I will speak about the broader HR requirements of what we are looking for and then I will defer to Debra to give the on-the-ground quality attributes of a good peer worker. Yes, [certificate IV is our minimum requirement. We employ SCHADS Award level 3 staff. They can be mental health workers or they can be peer workers. There is no distinction in the position description and there is no distinction in how pay people. The distinction is that we see lived experience as something that underpins our organisation throughout all of our policies. We are informed by it. We see lived experience peer workers as an added attribute and added value part of that job so someone can relate more readily to someone who is accessing the service.

It is a certificate IV in peer work or mental health. We encourage peer work. People who come on board might start off as a mental health worker and then would progress to completing their [certificate IV in peer work. We have social workers who go back and do a [certificate IV in peer work as part of their peer worker role. There is additional training, as Debra mentioned. There is Intentional Peer Support that is offered largely to peer workers, but we see there is value in that to other mental health workers as well. From an organisational perspective, there is no distinction. Level 4 qualifications are required to become a mental health or peer worker. There are other qualities about how people use their lived experience. It is not just the fact they have a lived experience; it is how they use their recovery. That would be the point where I would hand over to Debra, who could better answer that question I think.

Ms Gibbons: Yes, we are looking for staff and recruit staff who can draw upon their lived experience in a beneficial and purposeful manner, rather than one-upmanship or comparing war stories or vicarious traumas or giving too many details of your own. A personal experience can simply just be worded that way: 'I've had a similar experience.' You are mentored by more experienced peer workers or mental health workers, by myself as well and throughout the organisation. You are correct: not every person with a lived experience will make a good peer worker, but they can progress through those steps and those stages with guidance and training.

Mrs McMAHON: You mentioned groups: you have people come in, you identify a need and you establish a group around that. Can you run us through how that works? Can you give us a theoretical example or a real-case example where you have had people come in and you have identified a similar issue? How do you then structure those groups to deal with that? What are some examples of groups and issues?

Ms Gibbons: For any of our groups it is up to the people who access the service to share that with each other and, more importantly, with us. For example, a couple of years ago or 18 months ago, some participants were accessing the service who identify as having a lived experience with mental health challenges and also living on the spectrum. They wanted to have an ASD group. We talked about it over a few weeks and discussed what that would look like, if three or four people would want to come to the group, whether we can fit it into the schedule or we can negotiate where the space might be. A lot of groups are out in the community—it might be in a park or somewhere. The ASD group now runs every Monday from 1.30 until three. Sometimes there are two people and sometimes there are eight people in the group.

Mr Matthews: Things like men's groups, women's groups, and health and fitness plays a role. We run health promotions throughout the organisation. That is where it would be no different at a peer operator service.

Ms Gibbons: Music groups and cooking.

Dr ROWAN: I want to ask you a bit more about the peer workers. There are two parts to it: one is around further professional development opportunities and then also with those clients that the peer workers are supporting, people with particular issues. Locally, what is the availability of arts and cultural programs, employment opportunities and education opportunities that they can be linked into? They are providing support, but what other additional things can people be linked in to, to get a sense of what exists locally?

Ms Gibbons: We also have the other stream of our service, which is NDIS support. I believe the peer operated service, for many years before NDIS came into play, once we get to know the person, get an individual recovery plan, find out what their hopes, dreams and aspirations are. We have had good connections with Queensland Health, community mental health, doctors and psychologists. I will go back to our groups. Most of our groups will access communities. They might want to go and visit the art gallery or some of them might want to do art groups, so we just go out and find out that information together.

Dr ROWAN: Do a lot of those things exist locally as far as opportunities are concerned, if people want to join community choirs, get involved in things or have educational employment opportunities. Is the range of things that exists locally sufficient? Does it need more support? Do you have any recommendations about those things?

Ms Gibbons: We could always have more resources. Off the top of my head, I cannot really think of anything specific.

CHAIR: In terms of your one-on-one programs, are they an evidence based program? Do they have a start and a finish point? Is there a goal that you are trying to achieve with individuals who come into those programs? How do they work?

Mr Matthews: To best frame it, they are different streams. That is how Queensland Health set them up. Under the peer operated service, there are three different streams. They have just combined the WarmLine into the individual peer work stream. Within that, the development of the individual recovery plan is where those goals are identified. That would be what our outcomes are based on; that is what we would measure. As far as the time goes, it is 12 months but one of the challenges we have with funding models is that it does not necessarily fit how people need and how they do access, in this case, a peer operated service.

CHAIR: How are your group programs funded? Are they funded through NDIS or block funding from Queensland Health?

Mr Matthews: Under the peer operated service, funding is through Queensland Health; that is another stream. Under the one contract, we are funded to provide individual peer work, group based peer work, WarmLine and the respite house.

Ms KING: I want to ask a little further on funding. In the course of this inquiry, we have heard from other organisations that with the advent of the NDIS there was increasing difficulty and complexity around funding group-type services. Can you comment on that? Is there a way you get around it? Are your group services restricted in who can access them?

Mr Matthews: Yes, there are some complexities. The NDIS has not made it easy to establish services, though it is done. We run a program of supports but it offers challenges. It brings, in many ways, a structure. With the 12-week programs, we are finding that a lot people cannot commit and do not want to commit to 12 weeks. We have just reviewed that within our services across all of Flourish Australia to look at how we can build into those programs the supports so people can access groups more ad hoc rather than planning ahead.

As far as the groups that we were talking about, that is funded through Queensland Health. We have a no-wrong-door policy as well. What that means is that, in this case, we would not deny someone access to service but we are also mindful of their NDIS plan. We would be encouraging them to either access our groups—at the moment they are actually combined and we work through separating that out and what gets paid for where. That is another level of complexity. But we are pretty good with our group program up here. It has been one of the successes.

Even through COVID it showed the model and how successful they are. Whilst our role is pretty much a facilitation role within that, as Deb pointed out before, a lot of groups continued because people still wanted to do groups so they would organise it themselves. We would provide the resources where necessary. Now we are moving back to centre based groups. Obviously we go back to our normal role. There are some complexities, but we just have to work through them.

CHAIR: In terms of Flourish more generally, are you the regional manager for this particular region or is your region Queensland?

Mr Matthews: South-East Queensland.

CHAIR: Does Flourish have similar services elsewhere in Queensland and South-East Queensland?

Mr Matthews: Under our Queensland Health funded programs, we have a transitional recovery program that operates out of Caboolture and Redcliffe. That is a short-term residential supported program for up to 12 months and six months outreach support. There is the peer operated service here. Then we have NDIS services where we offer community support, core supports and support coordination.

CHAIR: In all of these services, is it always peer workers involved and people with lived experience involved in the planning and development of the services?

Mr Matthews: At varying levels, yes. As I mentioned before, with Flourish Australia lived experience is what underpins our service. That is reflected at all levels through our policies and how we approach providing support to people with a lived experience. With a peer operated service, it is all peers. We have an affirmative action policy. We ask the question, 'Why not a peer worker?' With every vacancy that is where we start. We are not specifically just hiring peer workers, but we are consciously looking for peer workers. We have a mix: across the organisation, 55 per cent of our staff identify as having a lived experience—we are just shy of 900 staff across all states—and about a quarter are peer workers.

CHAIR: I want to ask a sensitive question. I do not want to suggest that people with mental health issues always have challenging behaviours. I am interested in the involvement of peer support workers and people with lived experience in the planning and the delivery of services. It would seem to me, given the nature of some of the services you offer, particularly the residential services, that occasionally you will have situations where people are exhibiting behaviours that are challenging and difficult to manage for the volunteers or staff and also for other people in there. What strategies has your organisation developed to deal with those behaviours?

Mr Matthews: With the individuals themselves?

CHAIR: Yes.

Mr Matthews: We start with the peer operated service. Under the IPS model, in terms of that training, one of the underpinnings is mutuality so it is very much at the interpersonal level. It is how they establish a working relationship and that underpins everything that they do. We would certainly be implementing that. We have the usual workplace health and safety risk management processes that we have in place. Risk management plays a key role. We balance that out with dignity of risk as well. Inherently, with people with those bad behaviours we seek to understand what is driving those bad behaviours in the first instance. Usually, that is effective. Then we work with the individual to figure out how we can make things better and not worse when we are providing support right through to the last resort, which is if the service is not appropriate for that person then we would make a referral on.

CHAIR: Debra, did you want to add anything to that?

Ms Gibbons: Definitely what Trevor just said: that intentional peer support model is engrained in all the peer workers at the peer operated service. It is not that we do 'for'; we do everything 'with'. That is from the get-go of the introduction. If you are a new service user then that is shared with the new service user so from the get-go of the commencement of supports we share that. This is about a relationship; it is not about what I do for you or that I am the expert. You are the expert on you.

Mr Matthews: If it is NDIS, there may be a behavioural support plan that comes with that person. We work with clinicians and family members to resolve the issue so that the support can continue and then there is another side: obviously if there is an incident then that gets investigated and that gets looked at more closely. We are using that information to inform us on how to better provide that service to that person.

Dr ROWAN: I want to ask about the impacts of COVID. What have you seen from that perspective? Has it exacerbated things or are there new issues that have emerged as a result of that? What are you seeing in particular demographics as well?

Ms Gibbons: When COVID first commenced, of course we were all concerned. We all had to pack up, go home and work from home. There was a lot of research and medical professionals saying, 'We're going to have to really care for our people who live with mental health challenges.' I found the complete opposite, to be honest. Sometimes not a lot of credit is given when credit is due. If you think about it—and I thought about it for myself too—someone who has been at the very depths of mental health challenges is already isolated from community. We have already experienced what isolation feels like. We already have anxiety about going out to the shops or getting our hair cut or going to get a meal. Do you know what I mean? We already had that there. It was the people who have never experienced any mental health challenges who were really facing that.

In saying that, there was concern about the people who accessed our service but it actually made us stronger and brought us closer together. It is about what Trevor shared before and what we have been sharing it about groups. We had two or three groups that were created just because of COVID. We have what we call a pop-up group, which is a social group. It was created because of COVID because we could not have the groups in the centre. It definitely had positive and negative impacts, but the positives were that people learnt how to use technology or were not so fearful of technology in the communication realm. They found that they were more resourceful than they realised.

Mr Matthews: The experience was varied as well. Deb and I have had many conversations on the difference between the response from people in Hervey Bay versus people in Caboolture by staff and people accessing the service and more broadly. We have seen a drop-off, especially in lockdowns. We implemented our COVID-safe plans and restrictions meant that we could not do face to face. When we could not do face to face one thing we did find was that groups were significantly impacted. We tried to go online and even do one-on-ones over the phone. That was challenging for people. It is hard when you normally do two or three hour support to spend time on the phone, for both ends of that phone call. It was groups and one-on-one. What I have noticed, too, is that disconnection that it has caused. It is not that once the lockdown is over and once the restrictions are lifted everything comes back to what it was previously. We find that it has created a disconnection with people or from people accessing our services. Even if it is a few days or a week it can cause a separation and then it is reaching out and continuing on their supports.

CHAIR: It would seem to me that a lot of your services are probably for people who have been diagnosed, have got reasonably advanced disease processes or have been through an admission into hospital et cetera. We have heard a lot about people being diagnosed and there not being a lot of support out there for people when they are newly diagnosed. There are not many services in that space and people have to wait until they are admitted to an acute service when the disease has progressed so far. Has Flourish, anywhere in Australia, had experience of trying to work with people who are relatively newly diagnosed to do that preventive work around stopping disease from progressing, if that is in fact possible?

Mr Matthews: In New South Wales we have the YPOP program. We started it as a pilot down there. It is working specifically with youth. We also have four headspace centres in New South Wales as well. That is the area we largely work in. Other than that, we are speaking more informally. At the POS it would be people introduced to the peer operated service. Often that is the first time they are reaching out for any sort of support. That is where the experience would be not in a clinical sense or a formal sense; it would be more just being there and saying, 'Hey, we kind of know where you are coming from,' and supporting people in that way. Other than that, there are the youth programs in New South Wales.

CHAIR: I would like to thank you both for coming along today. Your contribution today will certainly help us to draft our report with recommendations back to government and hopefully it will improve the lives of people with mental illness. We would like you to take back to your volunteers and your staff our thanks for the work you have done over the last couple of years. It has been a particularly difficult couple of years in terms of managing COVID. We have heard about the impacts of it this afternoon. Thank you very much for the work you do. Thanks for your presentations here this afternoon. I now welcome the next witness.

OBER, Mr Stevan, Chief Executive Officer, Galangoor Duwalami Primary Healthcare Service

CHAIR: I would like to repeat that the committee respectfully acknowledges the traditional custodians of the land on which we meet today and pay our respects to elders past, present and emerging. We would ask you to make an opening statement to the committee if you so desire and then we will go to some questions from the committee.

Mr Ober: I am the CEO of Galangoor Duwalami Primary Healthcare Service. We are an Aboriginal community controlled health service here on the Fraser Coast. We also are a member of the Queensland Aboriginal and Islander Health Council and also the National Aboriginal Community Controlled Health Organisation in Canberra.

Our role on the Fraser Coast is really to try to support our Aboriginal and Torres Strait Islander community across primary health care. That is from birth to death. Also for us it is around when we look at mental health, how do we encompass that within Fraser Coast? The biggest thing within the primary healthcare sector at the moment within our region or within the Queensland government and within health is that it is a very medical model and it does not really accommodate the cultural and emotional wellbeing of Aboriginal and Torres Strait Islander people. Our job is to try to engage government services to think a little bit differently on the primary healthcare scale, but also think not just how it is affecting the individual but how it affects the whole family. To do that we have to have the right workforce. That is the area where we suffer a little bit in the sense that the current workforce is a very clinical workforce and a very acute workforce. It does not look at the primary healthcare models that affect Aboriginal and Torres Strait Islander communities, individuals and families.

How we do that is probably the hardest thing because we have to try to amalgamate medical thinking into a primary healthcare delivery that is long term, not just short-term healthcare, for individuals. For us it is about how do we do that, how do we resource correctly but also how do we advocate for our communities to all levels of government to make sure that is articulated correctly?

CHAIR: In terms of your service, you said it covers the Fraser Coast. Are you talking just about Hervey Bay and Maryborough or a bigger geographical area again?

Mr Ober: Fraser Coast for us—we go all the way down to Curra, just outside Gympie, all the way up to the tribal boundaries of the Butchulla people, which is just north of the Burrum River, and down around Poona is our most southern boundary. We cover a fair bit of the Fraser Coast. It is the same hospital area as the Wide Bay HHS for Fraser Coast, Maryborough and Hervey Bay hospital boundaries.

I am also a Central Queensland director for QAIHC; that is the other hat that I wear. Today I am also advocating for the whole of the sector around how we improve the opportunities for our population to access acute care and also access services with a primary healthcare focus that are long term not just short term and that do not just look at the presenting issue but at the long-term aspects of mental health care for individuals.

CHAIR: In that area you just described, I imagine the people who use your service or are part of your health service are Indigenous people living in mixed communities rather than distinct, discrete Indigenous communities like you might find in, say, Cherbourg or places like that? They are people living in a town like Hervey Bay?

Mr Ober: Yes, that is correct. The thing that really plays a big part is that we are currently servicing roughly 3,000 of the 4,500 Aboriginal and Torres Strait Islander population on the Fraser Coast. As well as that, we are servicing inmates from Maryborough Correctional Centre once they are released. We are also servicing those guys. If you look at the current population of the Maryborough prison you have a total inmate count of almost 700 people, and about 140 of those are Aboriginal or Torres Strait Islander people. About 40 per cent of those 140 come directly from Cherbourg, so we are dealing with quite a few.

The Maryborough community itself is a transient community. We have populations that we deal with from Woorabinda, Cherbourg, Palm Island, Rockhampton and places such as Beaudesert—those areas as well. We are not just dealing with the Fraser Coast; we are dealing with a whole population that is quite transient; people who have roots back to the Fraser Coast but also have roots in other communities.

CHAIR: In terms of your organisation, you talked about the concerns around the medical model pursuant to HHSs and other organisations. Does your organisation employ peer support workers or Indigenous health workers? What is the staffing model that you use?

Mr Ober: Our staffing model is both a primary healthcare service—GPs are part of that team of course. There is a social and emotional wellbeing team, which is made up of social workers and a mental health nurse. We also have visiting psychiatrists from the Royal Brisbane who come up. We have psychologists who visit as well on a fortnightly basis to deal with that clientele. We also have a mental health nurse to support the visiting psychiatrist. We have not just got a GP, primary healthcare, health workers and transport officers model; we also have those other disciplines that service community members who are not necessarily acute; they can be managed within the community. My background is in health and I have been in Aboriginal and islander health a long time.

My thoughts are that it has only ever really been a bandaid service when you look at what you could be doing if you had the right workforce and do it in support of HHSs which provide that acute care type of treatment. We are trying to prevent our mob from getting to the acute-care phase. It is about how do we engage community, how do we keep them from getting to that acute stage where people are put in the back of an ambulance under a medical model or are put in the back of a paddy wagon and put under a justice examination or something like that? It is how we do that smartly, really.

The funding is not endless. It is not an endless bucket of money that is going to roll out across all sectors. How do we do that smartly, but also how do we do that as a joint initiative? The biggest thing for Aboriginal and islander health recently has been the health equity legislation change. That is probably the biggest positive that we have seen within the sector, allowing us to work quite collaboratively with HHSs across all aspects of HHSs across Queensland.

CHAIR: Could you step us through that a little bit more?

Mr Ober: The health equity strategy that was passed—there is a strategy that has to be developed within the HHSs around how they are going to improve Aboriginal and islander health. QAIHC was one of the key partners in the implementation and discussion paper consultations that happened with communities. The biggest thing out of this has been the bringing of the community alongside the HHS, side by side on the journey. It is about how we improve health not just in the community controlled sector but also in Queensland government, in hospitals, in all the community health aspects including mental health services. For us it has been about how do we get the voice of the people—and Galangoor is one of those adjuncts; they are the voice for the people, not take it on. Also how do we work and walk beside the HHS to make sure it happens from both a medical standpoint and a hospital standpoint but also from a primary healthcare initiative perspective?

CHAIR: I want to look a bit more deeply at the staffing you mentioned. You mentioned you have some psych nurses, social workers, a GP and Indigenous health workers. Are they all based here?

Mr Ober: I have two clinics; one is running in Maryborough. I have two GPs and a couple of nurses in Maryborough. There are health workers and a social worker sitting up there permanently. Then I have a similar model in Hervey Bay.

CHAIR: Then you have a fly-in fly-out psychologist and psychiatrist?

Mr Ober: The visiting psychologist is fly-in fly-out and then there is a fly-in fly-out psychiatrist.

CHAIR: They are the same people who come, more or less, all the time?

Mr Ober: Yes, all the time.

CHAIR: It is not ideal, but it is better than having different people show up every week?

Mr Ober: Yes. It is not ideal, but again it is about the continuity of care. The psychiatrist that visits has found that to run our type of model, our Aboriginal community controlled health model, it is not just a matter of prescribing somebody medication. It is also actually working with the family members. He probably has a waitlist at the moment that he is getting the psychologist to manage as well as getting the mental health nurses to support those patients while he is not onsite, in between his visits.

It has always been the dream of the elders who formed Galangoor to make sure it was an encompassing model but that we do not duplicate other services out there that can do it. We do a fair bit of liaison with other services like Relationships Australia, Bridges and Beyond Blue. Our social worker even has a partnership with the Queensland Police. We have signed an MOU with them so they actually call us first to have a bit of a chat to our social worker to determine whether it is really a mental health issue that the person is in there for, or is it something that is social work because it is a domestic violence case or something like that? We try not to put our community members in harm's way. At the same time we make sure we encompass what we do but also advocate that with all departments and all levels as a joint partnership.

Dr ROWAN: In your role as a chief executive officer of a primary healthcare organisation under the auspices of Aboriginal community controlled health organisations—and you mentioned you had an involvement with the Queensland Aboriginal and Islander Health Council. I want to get a sense of the engagement that happens with you from a mental health policy development perspective in terms of the HHS coming to you or the primary health network coming to you and seeking your counsel or advice or input—whether it is you or through your network. That is at one level, but also through the Queensland Mental Health Commission and more centrally with the Queensland Health Mental Health Alcohol and Other Drugs Branch. What is the sense of engagement that you have at those two levels—obviously locally, but also even more centrally—particularly around policy development that is going to assist organisations like yours in providing quality care in the region?

Mr Ober: I think it is probably the biggest advantage. QAICH is the state body for community controlled health services in Queensland. They have a policy arm that drives some of those policy decisions and even some of the submission papers and discussion papers that go up to government. They also get feedback from members first before they submit those papers up to government. Within QAIHC there is an alcohol and drug arm, a policy team within that. We are not looking at just solving mental health issues; it also has AOD factored into that. We also advocate for any AOD aspects to it as well.

The thing with QAIHC is that it is the policy arm. It is the voice of the 28 member services across the state that drive how we do business on the ground but it also provides that advice and suggestions to government around such things as mental health. The committee would probably have received a submission from QAIHC. That came back from the 28 members. QAIHC engages with its members on a regular basis. For us to inform policy it is about making sure the voice is heard but also that it is written in such a way that it goes up to all levels of government—not just health but education, child safety, the Department of Communities and all of that.

For us, QAIHC has been the biggest leverage for member services to get that voice. We as CEOs in our own member services also have a duty to QAIHC. We are also the fingers on the ground, what is happening within our own regions, within our own areas, so we also provide that voice vocally to the local members. I have Bruce in Maryborough and Adrian here in Hervey Bay, so I also advocate that voice to the local guys on what is both the stance of Galangoor in delivering that but also what is the stance from QAIHC's perspective and how we advocate that up the chain. To the point where, even for me as a QAIHC director, myself and the board have a joint partnership with Queensland Health. We all sit down and talk to Minister D'Ath around some of the key issues that we might see within our sector and how we leverage that or how we talk about it at a policy level. Because again, organisations for us advocate around how we do that in policy, but policy also advocates how we do that on the ground. What we need to do on the ground guides us in how we do that and whom we need to talk to about some of the key issues across the state.

Ms KING: Thank you for being here, thank you for the work that you do for the health of your people every day and thank you to your organisation and everyone who works in it. I wonder if you could talk to us a little bit about where the gaps are in terms of mental health support and family support for your mob here. If there was a new service created, where is the greatest need? What part of the spectrum of care is missing most acutely that you would love to see improved? I know that is a very big how-long-is-a-piece-of-string question.

Mr Ober: As I said, I started off as a health worker in the HHS back in 1995, I think it was. For me, it has been having the specialist care onsite doing the primary healthcare model. That is the biggest gap. I am talking about psychologists and psychiatrists onsite to do the primary health care, not the acute care. The issue that we have locally is that our mental health service is very acute. Unless you are at the real extreme end of your mental illness you are not going to get seen, and if you are seen, you are seen for a very short time and then you are sent out to your GP and your community organisations to manage. Aboriginal and Torres Strait Islander people do not want to be at the acute end because the worst thing that you see—and that we have seen probably over recent times—are suicides and deaths from mental illness because they have become too acute to be managed. It has been the very last, the end of the spectrum, and they have been in the too-hard basket to manage.

If you want a good model to work alongside acute care, you want a similar model of specialists in primary health care to do that. At the moment, within the Fraser Coast we do not have the specialist care in primary health care or in the community controlled sector, let alone in Aboriginal community controlled health, to manage community on the ground and keep them out of hospital, because you do not want them in the hospital. If you can manage them out of hospital it is the best way. As I said, my psychiatrist has a waitlist, so when he is here he only manages to see anything up to 30 patients.

I know that I probably have another 30 plus sitting on a waitlist who cannot be managed outside the realms of HHS management because they are not acute. We do not want to see our mob sitting in the back of an ambulance or a paddy-wagon suffering mental illness because they have either tried to commit suicide or there has been a social issue around domestic violence or something like that and they cannot see a way out of it. We are trying to reduce incarceration if we can.

CHAIR: Just to be clear, basically what you are saying is that whilst it is good to have a visiting social worker and a psychologist, you would much rather have more of those resources in your organisation full time and available to roll out a primary care model rather than an acute end-stage model.

Mr Ober: Yes. My psychologists are currently seeing roughly about 15 patients continuously, and the thing they say to me is that three visits are not enough. Three visits is not what primary health care is about. It is not what community controlled health is all about. It is about walking with them on a long journey, not a short journey. It is the same with our psychiatrist. Even though he only visits once every four weeks, I have had to get a mental health trained nurse who has the right to provide and prescribe to manage those cases in between his visits because we do not want them getting acute. If she can manage them within community management at home, make sure the medications are up to date, if they have to have injections then make sure they are getting their injections, then that is a better model to work with to keep them safe at home within an environment that they are familiar with rather than trying to have them in an environment they are not familiar with.

CHAIR: You talked a lot about mental health, but is it a fairly similar story in the area of alcohol and other drugs in terms of the services your organisation rolls out?

Mr Ober: It is. Our GPs provide the home detox regimes. I think the biggest thing around alcohol and drug stuff here is that we have a number of rehabs, but they are not culturally appropriate and culturally safe for some of our community members and it is too easy for them to walk out and be triggered by the things that have put them in in the first place. The biggest concern I have with alcohol and drugs is you can mandate somebody for three days under mental health legislation but you cannot mandate them if they have an alcohol and drug problem. We are very quick to judge somebody in relation to alcohol and drugs than we are mental health. I have seen people with mental illness who have been classed as alcoholics, but they are only alcoholics because that is how they manage their medication—and that is their medication—to their mental illness. If you really wanted to look at how you manage that, it is a dual-diagnosis model that still needs to continue in the sector. You cannot just have mental health and AOD as two separate entities because it just does not work.

CHAIR: We know that housing and other social determinants, but particularly housing, have a big impact on people's mental health. In terms of housing, what is the situation here on the Fraser Coast in the areas that you folks operate?

Mr Ober: Not good. We have a number of community members in Maryborough, especially elders, who are homeless. They come to us on a regular basis for treatment or even just for a feed or a cup of tea. Hervey Bay is the same. You are looking at sometimes $300 plus for a week's rent for a low socioeconomic young family, and we have a lot of young families who move here because their partners are in the Maryborough Correctional Centre and they have no other supports. So again, the accommodation we have here is not the best, but also we do not have accommodation here. I struggle even myself to provide accommodation for the young locums who come up for three months to provide GP services, let alone trying to house somebody for long periods of time with not just themselves but there might be four or five different children in the household.

Ms CAMM: My question is in particular around children and young people. Sadly, all of the statistics point to First Nations children being at high risk of suicide and significant mental health issues. What have you seen here? Have you seen things improve with initiatives, early intervention and some of the wraparound services and the collaborative nature of things I have heard about from other people who presented today? Are you ahead of the curve or are things still worsening for our Indigenous children in particular?

Mr Ober: I do not think it is worsening. As an organisation we do a fair bit with partnerships because we know we cannot do it all, but what is concerning is that the ones who do not say anything are the ones who will actually commit suicide or try and do something. The ones who cry out for help are the ones that you see. Over the last six months we have probably seen about four or five young people pass away not just from something that is stressful but also just from the passing of a family member where they cannot cope. There are those aspects. We are trying to work with services. We have done a fair bit recently with child safety. We are trying to do a tight partnership with child safety

around how do we support our home care kids. How do we support those kids on orders who move from house to house? How do we keep them engaged in our service to keep them safe? We are doing some of that stuff in the background.

Also we have just partnered with Maryborough high, I think it is, around a GP in the school, so they will be able to target some of the kids within primary health and the high schools there now to try and get some support to those kids who do struggle at school but do not say anything. That is a new initiative. We are partnering with the school and the principal to do that. We provide our GP and a nurse one day a week into the school to support the kids in the school. Maryborough high at the moment is probably our largest Indigenous population within the schools there, but we also deliver preventative healthcare programs under the Deadly Choices banner because we have a tight partnership with the Institute for Urban Indigenous Health to deliver. We make sure that we pick those kids up in the community whom we miss, and we are trying to do some community events now leading up to Easter around trying to do some preventive stuff with our young kids.

Ms CAMM: I saw Deadly Choices on there. I have schools that embark on that as well. It is a great program, so well done.

Mr Ober: Thank you.

CHAIR: I look forward to seeing you down at the touch carnival in Camp Hill later in the year. Thank you very much for presenting this afternoon. The information you have given us will be extremely useful for the committee in terms of developing our report and making some recommendations. I would also like to, on behalf of the committee, extend our thanks to you and your staff and volunteers for the work that you do all the time, particularly over the last couple of years during the pandemic. It has been, no doubt, a very difficult time for the health workforce, so we do appreciate the work that you have done. Thank you very much for today.

Thank you to Hansard and thank you to the committee secretariat, not just for today but for the last couple of days of travel. I now declare the public hearing closed.

The committee adjourned at 3.30 pm.