MENTAL HEALTH SELECT COMMITTEE

Members present:
Ms AB King MP—Acting Chair
Ms AJ Camm MP
Dr A MacMahon MP
Mrs MF McMahon MP
Mr R Molhoek MP
Mr BL O'Rourke MP (virtual)
Dr CAC Rowan MP

Member in attendance:
Mrs DK Frecklington 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

WEDNESDAY, 20 APRIL 2022

Kingaroy

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The committee met at 10.51 am.

ACTING CHAIR: I now declare this public hearing of the Mental Health Select Committee open. I would like to begin by acknowledging the traditional owners of the land on which we are meeting today, the Wakka Wakka people, and pay my respects to elders past, present and emerging. I know that I am joined by everybody on the committee in doing so. I would like to introduce the members of the committee. I am Ali King, the member for Pumicestone. I am the acting chair today in the absence of Joe Kelly, the member for Greenslopes, who cannot attend and sends his apologies. The deputy chair is Mr Rob Molhoek, the member for Southport. Other committee members are: Mrs Melissa McMahon, the member for Macalister; Ms Amanda Camm, the member for Whitsunday; Dr Christian Rowan, the member for Moggill; Dr Amy MacMahon, the member for South Brisbane; and Mr Barry O'Rourke, the member for Rockhampton, who is on the phone. The committee has also granted special leave today for Mrs Deb Frecklington, the member for Nanango, to participate. We welcome the member and appreciate her warm welcome here in her electorate.

The purpose of today's hearing in Kingaroy is to assist the committee in its inquiry 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. The public hearing is being recorded and a transcript will be made available in due course on the parliament's website. You may be photographed today—in fact, you have already been photographed today—and images may also appear on the parliament's website or social media pages. We do ask that people turn their mobile phones to silent.

KRAUKSTS, Mr Nick, Team Leader, Youth Services, South Burnett CTC Inc

MASHFORD, Mr Hayden, Residential Team Leader, South Burnett CTC Inc

REINBOTT, Ms Lee-Anne, Team Leader, Family and Child Connect, South Burnett CTC Inc

TEMPERTON, Ms Nina, Chief Executive Officer, South Burnett CTC Inc

ACTING CHAIR: Nina, we will ask you to give a brief opening statement and then I will hand over to the member for Nanango to see if she has a couple of questions. Thank you so much for being with us today.

Ms Temperton: Thank you very much indeed to all members of the committee. You are most welcome in the South Burnett. In fact, we are absolutely thrilled to have you because, like most people in the South Burnett, we very much feel like the forgotten people much of the time. Our statistics for suicide, mental health, general disadvantage, economic disadvantage—any kind of disadvantage—are extraordinarily high, but we so often fall in that little gap between various regions including Wide Bay-Burnett, South Burnett, Darling Downs and the western regions. We also service the South Burnett on an ad hoc basis now and then as and when it suits. It is wonderful to hear that the most influential people in this field, who can hopefully effect some change, are here today.

The CTC extends the same welcome. We are a large community organisation. We have about 210 or so staff. We do all the nasty work that is to be done. We are doing it happily because we care for our people. We have absolutely no mental health funding whatsoever, nor do we have funding for homelessness except for a very small bucket for crisis accommodation for young people which at best has six beds. If you take that as an indication of the lack of services in the South Burnett, where an unfunded organisation basically has to do very much of the groundwork on behalf of government and society, then we are a good example. Many of our frontline staff are present today, including team leaders from various sections who encounter issues around mental health service provision all the time. I would like you to address as many of your questions as possible to them, because they are the really important ones in this field. Again welcome, and fire away.

ACTING CHAIR: I might go to the member for Nanango for a couple of questions.

Mrs FRECKLINGTON: Thank you very much, Acting Chair and committee, for agreeing to allow me to be part of this hearing.

Nina, on behalf of the South Burnett thank you so very much to you and the CTC for what you do for our community. I will direct a question to Nick and then I would love to ask Hayden a question. Nick, you are someone who is on the front line. You have real examples of what goes on when you are dealing with suicidal youth in relation to the Kingaroy Hospital and the services provided in our hospital. Would you like to give the committee a particular example that you just relayed to me?

Mr Krauksts: This example came from a young person we had in our homeless shelter who has a history of being in care and a lot of trauma whom we know quite well through their involvement through our residential care services as well. This was around June or July last year. They were in our hostel and they started to show signs of what we thought were drug-induced psychosis. That is based on past psychoses this young person had been in. We tried to support them through the hospital system.

It started with an admission one night at Kingaroy Hospital. I was on call at the time for the hostel. I was called around about 3 am to go to the hospital to pick them up. When I got there I relayed concerns that I did not think it was appropriate they should be released. Although I am not a psychologist or a psychiatrist or a doctor, I was seeing warning signs in this person. Having known them for a very long time, I was really trying to advocate for them to stay in and be looked after and seen in the morning by a mental health professional because they do not have mental health professionals working at Kingaroy Hospital after hours. They brought her to me in a wheelchair limp and unresponsive, having taken her out of one of the beds, to see if I could get her to respond to me and agree to go. I tried to talk to them. They were slumped forward in the chair and not responding to anything I was saying at all.

They then started telling me this was behavioural and that they did not want to leave. So they were behaving poorly because they did not want to leave. They asked me to get my car and bring it around to the side so they could wheel her out to the car and I could lift her in the car and take her back to the hostel. I asked them what they would have me do if I was crazy enough to do it and they said, ‘She’ll have two options: she’ll either stay in the car and she’ll get cold enough that eventually she’ll stop this behaviour and get out and want to come inside; or you just leave her in the car.’ Obviously I refused. I said, ‘I don’t touch clients, to begin with. It’s not acceptable. She’s unresponsive. It’s clear something is going on and I just will not be engaging in helping her leave at this point. She’s not well.’ I left. I was called back a few hours later to basically try and pick her up again, and I refused. She was released the next day. We were told they were fine.

Mrs FRECKLINGTON: Nick, would you say that response is due to a lack of services from the hospital and/or overwork of the providers at the hospital?

Mr Krauksts: Knowing the hospital set-up—I am a local; I have grown up here and I know people who work at the hospital. There have been lots of reports from people I know and people I work with who have family members. People are overworked. It is really clearly understaffed. The people I was talking to that night were nurses with no clinical background in mental health trying to support someone who appeared to be entering a psychosis without knowing what to do. It was not even a doctor who was trying to have an input. The only thing that they really have at their disposal is an after-hours mental health call line to someone who does not know the area, does not know the staff, does not know our organisation or how much we know about these young people, and does not actually talk to the young person.

Although I do not agree with what they did and it is not an excuse, it is obviously a sign that there is not enough staffing and the staff who are there are perhaps not the right staff rostered on at the right times due to funding, or they do not have the right qualifications and they are overworked. I have had friends work in the Kingaroy Hospital as nurses who left and went to Toowoomba and other regions because they could not cope with it anymore. Yes is the answer to that question.

Mrs FRECKLINGTON: Maybe Lee-Anne or Hayden want to respond to this question. One thing I am interested in, because I hear this a lot, is how many sessions a week would be available to a young person who is going through trauma in one of your resi cares?

Mr Mashford: For the resi care if you are lucky it would be one a week—and that is for some of our more extreme cases—if not, fortnightly.

Mrs FRECKLINGTON: Would that be via telehealth and if so do you believe—

Mr Mashford: The vast majority are unless we are lucky enough to get them into CYMHS, who are also unfortunately understaffed. With CYMHS the worker would sit there with the young person for these meetings, but they will talk with doctors in Toowoomba via telehealth.

Mrs McMAHON: Could you explain to the committee the role of CTC and how it works in terms of any of the community planning or any other work that your organisation does with other government services in forecasting or in understanding the needs or any of that information sharing that happens? Obviously there is an example where the hospital has CTC's contact details and is seen as the point of reference. Can you explain to us if there are any working groups or coordination bodies that your organisation sits on with local government agencies?

Ms Temperton: I will give the first response to that and Lee-Anne will then be able to fill in the details. CTC is a multifaceted organisation. We do domestic violence, NDIS care for people with disabilities, foster care and residential care. We have a disability enterprise for employment. We are a very broad based organisation and fundamentally we are in the South Burnett whether we want to be or not, whether we get funding or not. People in need of any kind of service come to us.

Our vision and mission is that we fill gaps so that everybody has what they need in all aspects of their lives. We do so on our own if we can or by encouraging others and encouraging partnerships. Lee-Anne, as team leader in one of our services, is very actively involved in leading the local level alliances of all the other agencies.

Ms Reinbott: The local level alliance came out in 2015 when Family and Child Connect and the IFS—Intensive Family Support services—came around. It is a group. There are 24 services—government and non-government. We work together to identify gaps, how to build referral pathways, how to reduce bottlenecking—anything that is coming up. Mental health has been on our agenda since 2018. I am also the conduit to the regional RCYFC, which is the department. We serve as the community representative to all the government services there. We do a lot of work in partnership with the collaboration.

ACTING CHAIR: Can I ask whether your PHN is actively involved in that planning and collaboration?

Ms Reinbott: We do have a PHN who has just come up, the one that has replaced Margie, who was seconded to another position for three months; she is also part of that. Prior to that Margie Hams was also part of that. We also have Queensland Health, the CPIU—the child protection social worker. We have Anita Johnstone; she is the education in Queensland Health looking to build referral pathways and working together. Sometimes we do not have the funding, so we work collaboratively to see what we can do to influence change and support other services. In the community everyone has buy-in, and that includes the police, child safety and domestic violence services. We bring everyone together and we meet. We have working groups that meet monthly and we meet quarterly to discuss where to next in terms of our next strategic direction.

Mrs McMAHON: You mentioned there were quite a few different services such as NDIS and homelessness. Could you break down some of your funding streams? Some of them would be state and some would be federal. Without going into fine detail, where are the buckets of money coming from? Obviously you are providing multiple services here. Can you give a simplified breakdown?

Ms Temperton: It is quite easy. The vast majority is state funding. NDIS is obviously fee for service by the NDIA. There is one federally funded service called Reconnect in Murgon servicing the Cherbourg community. We do a lot of work in Cherbourg in various fields from youth work to domestic violence, counselling and activities and the like. The vast majority is state funding.

Mrs McMAHON: Is that communities or public works?

Ms Temperton: Communities. The vast majority is communities. There is the odd little bucket here and there from different departments for special projects, but overall it is communities.

Ms CAMM: My question is particularly for Nick and Hayden. My interest on this committee has been around young people and in particular adolescents in regional and rural communities. You will not be pleased to know, but your story is sadly very similar to stories in my own community and also in other parts of regional Queensland. What are you seeing is the biggest trend or contributing factor for young people in the deterioration of mental health? Is it factors pertaining to intergenerational change or being part of a system of care, or is it around alcohol and other drugs? Where do you see the key trends that are contributing to young people's mental health decline in the communities that you service?

Mr Mashford: In terms of the residential, a lot is just that trauma that the young people have experienced in their upbringing, their youth and what-not. Again, the residential structures are not perfect, so a lot of young people do have trauma and their mental health is affected through that as well. Occasionally there is drugs and alcohol as well. Also quite often it is about young people being

exposed to other young people with mental health. One person will come in with a bit of self-harm. Then another young person will talk to them and they will say, 'This works for me,' so they then experiment with it as well. From there we see more young people take it on.

Mr Krauksts: It is pretty similar across most of our youth services that I look after—trauma and family breakdowns. In the last couple of years we have probably seen an increased impact of homelessness and a lack of housing. Even in an affordable area like the South Burnett we are seeing the steady deterioration of people who are homeless who just cannot secure accommodation but have ties to the area and do not want to leave.

A lot of times we catch people when they are starting to talk to us about some mild mental health issues, but we cannot get them help, so we just see this deterioration. Our teams just try to help them. Although we think we understand young people quite well, we are not mental health professionals. We help them as much as we can through some soft counselling and trying to get them engaged in the community. Also when they are starting to recognise mental health issues within themselves they really struggle to find or to access supports that they need without feeling rejected by services.

Ms CAMM: Would you say there is also a lack of early intervention services in your community?

Mr Krauksts: Absolutely. There are generalist services like ours, but in terms of even getting them even to the doctors at the moment, the majority of the young people we have in Kingaroy cannot see a doctor in Kingaroy. They have to go somewhere else, which means they rely on us to transport them. Then there are waiting lists. If they want to see a local mental health practitioner, of which there are very few or a local psychologist, you might wait a month or two months for an appointment and then it is a month in between appointments, and they do not want that.

They do not want telehealth. I know it goes against what people think about young people being tech savvy, but a lot of the feedback I get from young people about our service and other services—one of the PHN services EACH, Proof Youth with the worker there—they are with that person; they are physically with that person and feel supported by that person because they are in a room or talking on a park bench with them and they feel supported that way. A lot of our young people who are very distrusting of adults who are trying to support them with these complex issues do not like the feeling of talking to someone on a screen; they are not sure if they even listening or not, 'Do they have me on mute? They are just sitting there nodding.'

Ms Reinbott: If they are at home—

Mr Krauksts: There is that as well, yes. In terms of telehealth services for our area, we have people at Wattle Camp or out on farms who do not have great internet access. They then still need a service to transport them somewhere to access the internet to get telehealth. Alternatively, they might be in a home environment and that is what they are wanting to talk about with their therapist or whoever it is—the complexities around mum or dad or siblings and how that is impacting their mental health. They are expected to talk about that in that environment where those people can listen in. It is not safe when they do not want to do it.

Mr O'ROURKE: Firstly, thank you to CTC for the great work they do in the community. My question is around Gumnut Place. The website states you have over 20 people with disability who utilise that service. I have two questions. Prior to the NDIS, around regional Queensland there was a lot of drop-in places for people with mental health issues. I am wondering whether Gumnut Place today are still supporting people with mental health issues with a drop-in service not necessarily funded by the NDIS. I also apologise. It is quite hard to hear, so I hope I have not asked a question that has already been asked.

ACTING CHAIR: Did you catch the question?

Ms Temperton: Was the question: do we support people with mental health issues at Gumnut?

ACTING CHAIR: Not precisely. The member for Rockhampton was asking about the difference prior to and post the implementation of the NDIS in terms of access to drop-in community support services. He was asking whether Gumnut Place provides that kind of a service. Correct me if I am wrong, but I think he was asking have you seen any change in the availability of those kinds of psychosocial support drop-in services with the change in the funding model under the NDIS?

Ms Temperton: The short answer is no, but gumnut Place never was a drop-in sort of service—not in the time that CTC has been running it, which is probably about 12 to 15 years. It is an employment place—supported employment. We pride ourselves on getting people into open employment through appropriate measures. The funding model has changed. They are now all NDIS

clients, which means there are more people in there for shorter periods than before, so numbers have increased, but for fewer hours. In my experience with Gumnut, mental health has not been a particular issue amongst those clients whom we support.

There are no drop-in type centres anymore in the South Burnett at all. People come to CTC as drop-ins. We do our very best to provide them with a service, but they have to fit in around the projects or services we are actually funded for, which causes major stress on our staff, of course. One of the aspects of the lack of mental health supports in the South Burnett is that our staff have to deal with an awful lot of trauma and vicarious trauma. Burnout is incredible because the overload is such that nobody goes home at the right time and nobody gets their lunch hour on a regular basis or any kind of breaks. If somebody is sick, which during COVID has happened increasingly, the load just falls on the others. However, in the absence of anything else, what are we supposed to do? We take people on, and the CEO and the board have nightmares about how we support our staff.

Dr MacMAHON: Nina, you mentioned economic disadvantage. I was hoping you and your colleagues could elaborate on how economic disadvantage is impacting on people's mental health?

Ms Temperton: We can. I hope I am not going to be quoted forever because I am not sure of my figures either; I am like a politician in that respect, I think. The South Burnett socioeconomic level, or whatever the descriptor is, is amongst the worst in Queensland and amongst the worst in the country. There are an awful lot of people who have moved into the area from other cities, especially because it is comparatively cheap. They have then found themselves here without services. Most of them have gone into five acre blocks or whatever else—no water, no power, no services and, above all, no transport, at all. So, obviously isolated mental health issues are just thriving. Relationships break down. We get back to the family relationship: the young people in those families are lost and follow on.

With respect to the provision of counselling, for instance, there are quite a few private counsellors around the place, but if you have $50 for the fortnight to live on, you cannot afford a private counsellor. There is the fact that people generally are poor. There is an extraordinarily high rate of people with disabilities for the same reasons who rely heavily on the provision of services from the hospital. They cannot get into doctors. Generally speaking, it can take years before you get into a private doctor here—at the very best, it takes months—so they overload the hospital with everything, which then leads to the escalation of their staff being overworked when they are not qualified to deal with mental health issues. The spiral keeps going.

ACTING CHAIR: I ask you to elaborate on this issue of doctor shortages. Certainly it is something that my community experiences in our area and, we have heard, the length and breadth of Queensland. What kinds of availability is there for those primary health GP services? You have touched on that.

Ms Temperton: I believe we currently have something like 25 GPs in the various practices in the South Burnett. I am not entirely certain of that number, but something in that region. They are servicing 35,000 people, roughly speaking, and every single clinic that I know of is not taking on new patients. Fundamentally people have to die to create a vacancy on a GP list.

A lot of the GPs are also here usually for fairly short spells. The established doctors have younger junior staff with them who stay for a year or two at most and that, of course, for mental health patients is then a major issue, especially for our young ones who are absolutely fed up with having to repeat their story time and time and time again and nothing happens at the end of it.

There is no paediatrician. The nearest specialists are in Toowoomba or Sunshine Coast. Again, there is no public transport. The Toowoomba Hospital has a history of, when clients get sent to Toowoomba from the Kingaroy Hospital or from anywhere else, to release those patients overnight, and there appears to be absolutely no care as to how these people, especially these young people, are then going to find their way back home. That is when we usually get a phone call, 'Can somebody from CTC come and pick them up and bring them back?'

Dr ROWAN: Thank you to the South Burnett CTC for all the vital community work that you do. When I was shadow minister for communities, disability services and seniors, the member for Nanango gave me terrific briefings on the work that you do. I want to acknowledge that because it is vital for the residents in the South Burnett region.

I want to come to two issues, building on what the member for Whitsunday was asking about a little bit earlier. Are there specific alcohol and drug issues or trends that you are seeing and, if there are, what those are, and what access and availability to detoxification and rehabilitation services there are locally? The second part of my question is around trauma related issues which were touched on earlier and if there are specific issues in relation to trends within families, whether it is childhood

neglect or abuse or particular financial stressors or social issues that pertain particularly to the South Burnett region which you are seeing which are underpinning the development of mental health or substance dependency issues?

Ms Reinbott: There is not any detox or rehabilitation services in the South Burnett. We have a video showing that they can attend every day for four days to get some support in drug and alcohol sector. We do have one drug and alcohol service that is a community service. Then we have the AODS at the hospital where there is often quite a long waitlist for families and our youth. I will let Nick speak to specifically the trauma in the youth with drugs and alcohol, but we are also seeing parents—it is very historical—come into the area. Also, working on our local level alliance, the police have noticed a large increase of drugs and crimes in the area.

Mr Krauksts: A lot of the trauma, as Leanne touched on, is that intergenerational family trauma. Especially looking at areas like Cherbourg, there is just so much intergenerational trauma and, understandably, a real lack of trust in services that are trying to support them, or interventional services, across the South Burnett in terms of trends with drug and alcohol use. We see a lot of what I would call maybe slightly less concerning use—like really broadly with marijuana, but then also the more pressing concerns would be amphetamines. Ice, basically, would be what we see most of the time with youth services with the more hard-drug addiction. Again, being able to access services to support them with that is really tricky. We see a lot of people present as a young adult, so we are talking the 18- to 25-year range. We service in the youth services for the older range. They may present to AODS up at the hospital and they are told, 'Oh, we think that Lives Lived Well might be a better fit.' They go to Lives Lived Well and they say, 'There could have been a dual diagnosis approach with this person at the hospital with AODS and the mental health team.' That seems to be a non-existent use at Kingaroy Hospital. There does not seem to be much use of a dual diagnosis policy.

I only found out about a dual diagnosis committee maybe two years ago when my partner worked at AODS in Cherbourg and said, 'Oh, have you heard about the dual diagnosis committee? I had a client attend it today.' I had never heard of it before then and I tried to get a client in on it and was told 'not appropriate'.

The No Wrong Door policy at the hospital really harms people presenting with alcohol and drug issues in the South Burnett. That is not being used. People will present with wanting help with alcohol and drugs. They will talk to them and it results in, 'Oh, look, it is more of a mental health thing. That is not really our service. You need to go and organise a self-referral to the mental health team.' A month later, they go and see the mental health team and they say, 'Mate, you are telling us you have all these issues. Yeah, you are using ice; your issue is alcohol and drugs. You need to go over to Alcohol and Other Drugs.' There are two services. Lives Lived Well do probably the best that they can with their situation, but they are getting more referrals than they can handle and are limited in their services because they are being pushed upon from the public health system.

Mrs McMAHON: One of the things that the committee is really looking at is the pressures in relation to workforce. We have spoken about the understaffing at the hospital, particularly in the mental health space. We have this as an issue throughout Queensland. Can you briefly talk about, within CTC with your various different services, what staff and qualifications that you have within your organisation and also whether you employ peer workers or a peer workforce in some of your service delivery.

Ms Temperton: We would love to employ peer services. There is no funding for peer workers. We are quite fortunate in that we are seen to be an employer of choice, so we do not have too many issues recruiting support workers for any of our various fields, but it is getting harder; so far it has been manageable. Turnover is a massive issue. As far as disability services are concerned, the amounts that the NDIA are willing to pay for qualified staff are inadequate. They are perfectly happy to have Certificate II or Certificate III workers; we prefer Certificate IV. We assist people getting to those levels, but then quite frequently feel that we are the ones who provide the training and the extra wages, and other agencies are then very happy to take them on, or those workers leave because they can earn so much more as private workers than working for an agency.

We are also lucky that we work with various universities and we get placements, and we try to keep hold of these people, which has been quite successful. However, again it is unfortunately one of those things where those young, fresh recruits stay for a year or two and then wander off to the bright lights of the city. We are a regional area; we have to acknowledge it is not for everybody.

Mrs McMAHON: To clarify, in relation to funding, there is no funding for peer workers?

Ms Temperton: Yes.

Mrs McMAHON: Is that tied to the funding models that you have for the delivery of these services that specifically exclude workers who are titled peer workers or would their qualifications be the certificate in peer work?

Ms Temperton: We have no funding for any mental health services, peers or professionals or whatever—none.

Mrs McMAHON: What about within the youth and homelessness services?

Ms Temperton: They are not meant to be mental health workers. They are support workers. They provide all sorts of supports. They can do some soft counselling. Some of them have qualifications, but that is not generally what they are employed for because the funding is not there for a mental health professional.

Mrs FRECKLINGTON: I would like to ask Hayden a question. Firstly, thank you. I know that the work you do in resi is incredible. How many of your youth who are in resi have mental health issues on a percentage basis? Are you able to guesstimate for us?

Mr Mashford: Out of the placements that we have?

Mrs FRECKLINGTON: Yes.

Mr Mashford: Let me do the maths.

Ms Temperton: There are 17 I think at the moment in resi.

Mr Mashford: I thought we had moved backwards a little bit. Either way, it is 15 or 17.

Ms Temperton: It is about 17.

Mr Mashford: It is a huge amount. I would say 75 per cent just off the top of my head—whether that is depression, anxiety, a schizophrenia diagnosis. There is quite a range.

Mrs FRECKLINGTON: If you had a magic wand that you could wave, what would you hope for for the youth in your residential care?

Mr Mashford: It would be great if we were not there. It is just better for them to be at home with families in a safe, nurturing environment. A magic wand is for me to be unemployed.

ACTING CHAIR: We will all keep hoping for that. Thank you for coming before us today and for your submissions. I have no doubt that your contributions to our hearings will make a difference in the production of our final report. There being no further questions, that concludes this part of today's public hearing. Thank you again for your time.

HAMS, Ms Margie, Youth Mental Health Coordinator, South Burnett Regional Council

ACTING CHAIR: Welcome. I invite you to make a short opening statement and then members of the committee will ask you some questions.

Ms Hams: I normally work at the Darling Downs and West Moreton PHN. I have been there for about six years. We started to do a project here in the South Burnett. It started off in one direction and then it changed to a direction where we focused on youth mental health. I have now been seconded to the South Burnett Regional Council as the youth mental health coordinator so that I can transition that project to council because obviously it has that sustainability.

ACTING CHAIR: Could you tell us a bit about your day-to-day activities and the mental health issues you see in the community for young people and what the local factors are?

Ms Hams: Do you mind if I start right from the beginning and how this all came about?

ACTING CHAIR: Go for it.

Ms Hams: It really all started when the Queensland Country Practice, which is an arm of Queensland Health, did a report on the Kingaroy Hospital. Even though that report focused on staff retention, culture and attracting staff to the South Burnett, one of the recommendations from that was that we start a Kingaroy Stakeholder Consultative Group. That group is made up of the Kingaroy Hospital, the South Burnett Regional Council and primary care. The PHN formed that group and it has been going now for about two years.

We meet probably once a quarter and we are in three working groups. The South Burnett Regional Council focus on liveability of the region, the Kingaroy Hospital focus on staff retention and attracting staff, and primary care is where the PHN sit and we look at gaps in services. We brought on a consultant from Brisbane, Louise Litchfield, and she introduced us to a model called the Jones family. It is a welsh model. Instead of talking in broad terms when we meet with the stakeholders, we developed a family called the Bunya family. We run scenario workshops; we do not just talk. We have all been in those meetings where everyone says, ‘Oh, yes. This happens and that happens.’ What we do is we make it more personal. We have created this Bunya family and as I said we run scenarios, so it is very personal and it is very focused.

One of the first scenarios we ran was a single mother with her teenage daughter, Lauren and Jan. Jan is a single mum who is 41 years old with no real health issues. She is a little bit overweight but nothing to worry about. Her daughter, though, is obese and bordering on diabetic. When we ran that scenario, we had actors come and play the parts of those avatars. The scenario we ran was that Lauren fainted at the family home on a Sunday afternoon. While her mum was able to rouse her, she still took her to the Kingaroy Hospital for medical attention. What that highlighted was that, had Lauren been admitted to hospital that afternoon, she would have been referred to services and been supported in her journey to get well. However, in our scenario she was not admitted; she was sent home.

That highlighted some things to us. Her mum was new to the region, so she did not have a GP and she did not know where to start and where to find services for Lauren, who is obviously overweight and having all of these problems. That is where the whole project kicked off. It made us realise that there are definite gaps in services for youth mental health in the South Burnett region. That is where it all started.

Ms CAMM: Does the South Burnett Regional Council receive specific funding from the state government or the department of communities for youth services or programs? As you outlined before, this was funded through PHN. Are there other funding streams as well that you receive?

Ms Hams: The South Burnett Regional Council did receive a grant for mental health through Queensland Health. I have been able to access some of those funds to do some of the functions in my role while I have been at council. When this project was first formed, we did some consultation with youth in the South Burnett. We did two youth forums—one at the Kingaroy State High School and one at Saint Mary’s. We would have liked to have done more, but obviously that is tricky. We had about 50 children aged between 13 and 15 come and do some work with us. We got them to create three new avatars for our family. Because they were not talking about themselves per se but they were creating those avatars and characters for our family, they were very open and honest about what is going on in the region for them. They talked about mental health issues. They talked about drug use. They talked about the things that impact them not being able to access services because they live out of town and there are funding gaps in services. They also mentioned privacy—in that they have to tell their mums and dads they are looking for services. A whole range of things were uncovered through those forums. In my role at the South Burnett Regional Council, the youth made

some recommendations for youth activities. They highlighted things that they thought would help generally with their wellbeing. I have been able to access those funds to make those recommendations come to life.

Ms CAMM: With all of the information you were able to gather through those activities, were you able to go back to Queensland Health and say that there is a greater need? We have just heard from CTC that the need is significant but the services are not there to meet the need, particularly for adolescents. Has there been a dialogue with the council back to Queensland Health to say, 'We do need more'?

Ms Hams: I do not know that that has happened. I know council have made a lot of noise about what is going on out here, but I am not sure what has happened formally. I know that the PHN also are very aware of the gaps in services in this region. Even if we had unlimited funding, there would just not be enough. Even attracting people to rural towns is a challenge, and there is no housing here. It is more than just one little thing. It is such a big issue.

Ms CAMM: It is complex.

Ms Hams: Yes, it is.

Mrs McMAHON: I want to have a look at the role of council in this. We have been to a lot of areas throughout Queensland but very rarely does council get involved in the delivery of mental health services. Usually it is limited to just state and/or federal from that general health funding. From your experience working in larger health delivery services, where do you see the role of councils, whether it is regional councils like yours or even some of the larger urban councils? Is there a place for councils throughout Queensland to be involved in this youth mental health space?

Ms Hams: I do think they have a great role. Our funding cycle is only three years, but council is going to be here. If things sit with council, they are more likely to be sustained over a longer time. Council have that connection with community. I truly believe it needs to be a community response; it is not just about having services in place for people. It does not necessarily have to be a clinical response. There has to be more at the other end.

Mrs McMAHON: Where do you see potential? Within the grand scheme of local, state and federal, where do you see the niche for councils to be involved in the youth mental health space—or just the mental health space more broadly?

Ms Hams: Through my role now I have that connection. I suppose through the council I have connection to community groups and non-government groups. As I say, if we can work together; it has to be a more coordinated approach. I think council has that community connection. That is where I think having a role like mine in council—even for a short time—we have made some strides towards assisting young people.

Mrs McMAHON: Do you see your role as more of a coordinating role amongst the NGOs that are in your council area? Because they are obviously all delivering various different services, so I guess you potentially have a bird's-eye view of who is delivering what and who is not. Then is it a matter of helping with referrals or what limited funding council has to then fund some of those NGOs as well?

Ms Hams: Yes and no. Through my role I have just established a youth mental health oversight group. That is something I think will be significant. We have decision-makers around the table. We have the CEO of the PHN and the commissioning leads. We have people from Child Safety, CTC, Queensland Health, the Department of Education and Catholic education. I feel like we need that coordinated approach, and that is where I see the gaps are. Council can bring people together because they are the council. Even PHNs, while they can do certain things, they cannot do what the council does. The council has that strength and community backing to make sure those things continue on. I do think a lot of stuff should sit with it only because it should be the source of truth. You go to meetings and you hear what people have—because, like you said, everyone is doing their own little thing, but there is no coordination between the groups. I guess somewhere, somehow, there has to be a source of truth so that people can find out where to go and what to do if they are having mental health issues.

ACTING CHAIR: You mentioned the Kingaroy stakeholder consultative group and the youth mental health oversight group you have put together. Do you think there needs to be, either in of those groups or in a different setting, more NGO voices into that kind of regional planning?

Ms Hams: The way we have set it up is that—we have groups everywhere—we did do a scenario using our youth avatars and we did invite all the people who work with youth mental health in the South Burnett. It was really exciting because, even though the scenario did not come up with all the answers, it was literally the first time all of our stakeholders were in the same room together.

We had ambulance right through to the end when they are discharged from hospital. You are right: the NGOs and service providers that provide services that are not always tied into the acute part of mental health do need to be included, but I guess the way we set it up is that in the oversight group we have the decision-makers, like I say, so I guess they are the ones that probably hear the most from NGOs and other community organisations, and they will table those issues they find.

Dr MacMAHON: I wonder in your role if you have identified any particular challenges for Aboriginal youth in the region.

Ms Hams: Yes, there are transport and remote issues, but we do include Cherbourg and Murgon in all the things we do. Yes, obviously it is a given that they have challenges, as I say, remotely and social challenges et cetera as well. Yes, we are very aware of that. We are trying to be as inclusive as we can be with the work we are doing.

Mrs FRECKLINGTON: I appreciate the work you are doing. I have a follow-on question from the member for Macalister's question. Given your experience in the past, I am quite interested in this area where we have such issues around youth mental health in particular—not just youth, but mental health. I think you have already answered this, but is council really the best place for that mental health funding to sit, given that the expertise sits with so many of our NGOs?

Ms Hams: I do not know that the funding should sit with council, but I suppose the role of coordination should sit with council.

Mrs FRECKLINGTON: The other question I have is: we know that suicides among young people are extremely high in the community, particularly in Cherbourg. I am interested in the coordination that you are leading via council with the Cherbourg Community Council as well, because my understanding is—and correct me if I am wrong—through the coordination approach that you run there is no community youth mental health service dedicated program in Cherbourg. Does your group work with the Cherbourg Regional Council to tie it all together for this region, or do you separate them away?

Ms Hams: I have not really worked with the Cherbourg Regional Council. The South Burnett Regional Council has just established a youth council. That has 18 young people, and we have included Cherbourg in that. We have three representatives from Cherbourg who joined our youth council, so I guess that is another avenue where we get an opportunity to hear their views and work with them to find solutions if they identify things in the South Burnett. We are trying to be very inclusive.

Mrs McMAHON: What are you hearing from the youth council?

Ms Hams: We have only just started, but through the nomination process what we hear mostly is that transport is an issue, obviously, when they are living remotely—because a lot of kids live on properties around the region; they do not all live in town—and having nothing to do. That is the biggest thing. One of the questions for the nomination was, 'What would you change about the South Burnett to make it nicer to live for a young person?' Most of them say they would like more activities for their age group. There is lots to do when you are a kid in the South Burnett, and as adults we think it is a great place and we can always find things to do, but kids of 15 and up—

Mrs McMAHON: And that probably really is a council area, working in the provision of community activities and funding those community activities.

Ms Hams: Yes. It is funny, but the recommendations from the youth forums that we held—they do not want outrageous things. They want normal things. It is like everything old is new again. They want to know how to cook, how to write a resume, how to dress for an interview, how to put a bit of make-up on. We had two young women ask, 'How do you have a baby?' I am pretty old, so when I went to school we did parenting classes. We actually had a health nurse come in every week for about six weeks and show us how to change a nappy and bath a baby. All those things just do not happen these days. It is a strange time, isn't it? They all have 1,000 friends on social media, but a lot of them do not have one person to whom they could say, 'Hey, I just feel sad today.' Do you know what I mean? It is a strange time.

ACTING CHAIR: I think we can let that otherwise unparliamentary language slide.

Ms Hams: Oh, I am sorry! I said, 'I just feel unwell.' I am very Australian.

ACTING CHAIR: The member for Moggill looks like he is burning to ask a question.

Dr ROWAN: Thank you, Chair, and thank you to the South Burnett Regional Council. I want to ask about the health workforce, because we have been hearing throughout this inquiry that there are specific challenges, particularly in rural and regional Queensland, and particularly for health

professionals. Do you have any advice or suggestions in relation to recruitment and retention in relation to GPs, social workers, psychologists or psychiatrists? There are some models where councils have collaborated with PHNs to provide services in specific areas to assist, augment and enable other service provision without necessarily competing with existing providers. We know there can be some complex sensitivities around existing general practices or other community organisations. Do you have any suggestions around what more can be done to recruit and retain health professionals? Is there any consideration by the South Burnett Regional Council to collaborate with PHNs or other levels of government to provide niche services in particular areas?

Ms Hams: It is such a big issue. If I put my PHN hat on, I think we only got two registrars in the South Burnett this year so we are dreadfully undersubscribed in registrars.

Dr ROWAN: Is that with the GP training program?

Ms Hams: Yes, that is your GPTQ. South Burnett is lucky: we have the Long Look Program. I do not know if you know what that is. The Long Look Program is through Griffith University. We have an opportunity where medical students can come to the South Burnett and stay for 12 months rather than a six-week rotation, so they become part of our community. I do not know what the answer is to staff retention. I always think there is real merit in a grow-your-own workforce. You could give people an incentive to come to the country, but I do not know if that would be sustainable either. Like I say, housing is such an issue as well. Even if we had unlimited resources, where would they live? It is just such a problem. I think our South Burnett Regional Council is very open to working with the PHN. We have established a good relationship through that stakeholder public consultative group, so I think that is probably a good solution. I do not know what the answers are as far as staff retention and attracting people to the South Burnett.

Dr ROWAN: Subsidised housing potentially, professional training opportunities?

Ms Hams: Yes.

Dr ROWAN: Are there programs for assisting spouses to get employment as well?

Ms Hams: That is another thing. Maybe the South Burnett Regional Council, with that connectivity to community—I know that through the South Burnett suicide prevention working group we have some funding to start a young professional social group, and that is something I am working on as well. When I look at places like Goondiwindi, when they have young people come to live there or to train there, they stay. I think it is because they have that amazing connection to community right from the get-go and I think they are really embraced, whereas South Burnett is not quite. It probably was a couple of years ago, but we have had a big turnover in staff at the hospital. GPs are getting old, they are all starting to look at retiring, so it is going to be a real problem in the South Burnett in the future. We really need to find a solution. We need to act quickly.

ACTING CHAIR: We hear over and over that homegrown is the only way forward for regional communities that is sustainable. If a young person grows up here in Kingaroy and they want to train in an allied or health support role, whether that is aged care or as a social worker or perhaps even as a psychologist, what are their pathways? What do they have to do or what is available?

Ms Hams: They will obviously have to go through to uni. We work with RMEA and SQRH, which is Southern Queensland Rural Health. It is called Aspire to Health. We have training days for year 10 students who come out and have a go. They have all the allied health workers there and it is like a speed dating thing. They go around and they talk to the allied health workers and do a scenario. They do plastering, they do some sutures and they put in a drip. It is a good, fun day. So I guess more days like that, because they do talk about the pathways. They discuss that you do not just have to go to university and you do not need an ATAR of whatever. They talk about other ways around getting to where you want to go. Maybe it will take a little bit longer, but days like that are certainly beneficial and I guess more things like that in the South Burnett would be great.

Dr MacMAHON: After listening to you and the previous session, it sounds like isolation and transport are two big issues. What would be your recommendations around transport and helping people get to where they need to go?

Ms Hams: It is so tricky here because it is a big region. It is not as simple as just having a bus. You could run buses from Nanango or Blackbutt, but then it is a problem for people to get to Nanango or Blackbutt. CTC are an amazing organisation and they have cars and they have transport. They can only use their transport for CTC programs though. We could look at partnering with organisations like that which have access to transport. Building those relationships is so important. The South Burnett Regional Council are putting in a tender for a resource infrastructure grant. We have already

talked to the CTC about partnering with them. They are such an important player. In terms of transport, I cannot think of any other solutions. I have thought of asking RSLs because they have a courtesy bus. I do not know. It is such an issue. The thing is that not everyone lives in town.

Mrs FRECKLINGTON: Margie, thank you for your frankness in your answers. This may be outside your current role, but I know you have had so much experience with the PHN. Your PHN is Darling Downs and West Moreton so that covers roughly this area. What percentage of that PHN funding would go to mental health?

Ms Hams: I would have to ask someone but I am happy to find out for you.

ACTING CHAIR: You can take that on notice.

Ms Hams: Okay.

Mrs FRECKLINGTON: That would be wonderful.

Mrs McMAHON: Our information says that last year you held a South Burnett Health and Community Services Expo. Could you tell us a bit about the genesis behind that, what came out of that day and what lessons were learnt going forward from your point of view?

Ms Hams: Again, from the youth forums, we heard the kids say that they did not know what was available in the South Burnett region. I hear that often in meetings that I go to. People are not aware of what others are doing, which is fairly common. We hosted that event last year and we had 55 exhibitors. We had a meet and greet at the end of the first day and we had 75 people attend the meet and greet, which was amazing. It was good for our first go. The council are not very good at marketing so next time we need to have a better marketing plan for the community. The uptake from service providers was really good, but there were not as many community members as I would have liked.

Mrs McMAHON: Who was your target audience?

Ms Hams: It was young people but it was all community members. It was at the town hall in the main street of Kingaroy and was held on a Thursday and Friday. We wanted people to just walk past and come and meet service providers, and we also wanted service providers to have an opportunity to meet community members.

Mrs McMAHON: Do you have a relationship with your local high schools in terms of potentially hosting those kinds of days during school?

Ms Hams: It was tricky with the high schools. We did invite them to come along but it was hard because it was in November so it was a terrible time of the year. They were all in exams and it was towards the end of the year. Next time we do it, we will try to do it at a different time. We also need to think about what we can provide for a younger audience. We did have service providers who had walking aids and we opened it up to all of the community. It was not targeted enough at youth so we have to look at doing something like that. I put out a survey after the event to all of the people who attended, and I can say that 100 per cent of the people said they met a service provider they did not know existed in the South Burnett so that was pretty good. The networking amongst themselves was pretty good, and they all want to do it again this year. We will have to look at doing it again. I did learn a lot from that event.

ACTING CHAIR: When I was researching for this hearing and I looked on the council's website, I was really impressed by the compiled lists of services that you offer for the region. I do not think my own local council would have such extensive googleable resources for people to see numbers and services, so I do congratulate the council on that. I was really impressed with that. I want to change tack a bit. In your roles both currently and at the PHN, what can you tell us about the impact of stigma when it comes to people identifying themselves as needing support for their mental health and then seeking that support here in the South Burnett as a regional and rural area?

Ms Hams: You would say it was more prevalent here because we know each other. There is always the risk that if you go and see someone you will be seen by somebody you know when you go in. Stigma is a massive issue. Even the young people through those forums identified that as an issue, so it is obviously something. I know the PHN commissions services for some group sessions—just for physio and things like that—but even that was tricky. It is different in the city. I am not being awful, but I do not want to be in a session with the lady from Woolworths. I do not want her to know that I have a heart issue, for example. It is tricky in a country region, and I think that has to always be considered whenever you set up any sort of service.

One of the recommendations from the youth forums was to create a youth hub, like a safe space. That is something we are working towards at the South Burnett Regional Council as well. Again, it has to be a space where young people can feel comfortable to go and not feel like if someone

sees them go there it is just because they are unwell. In thinking like that, we have to focus on mental wellness. When you talk mental health, it does not necessarily mean mental illness; it is keeping young people healthy and well before they get to that point.

ACTING CHAIR: We certainly heard that in some of our other regional travel. I am thinking of a particular service provider in Hervey Bay who talked about almost having to disguise the services that are designed to support people's mental health. They have to make them about something else in order to get particular cohorts to attend them. I think they were especially referring to men. Do you see that there has been any generational change in people's willingness to talk about mental wellness?

Ms Hams: Out here in the country, there are the farmers and the men who are proud and are deemed as being strong and tough. I guess it is always a problem out in the regional areas to break down those barriers. I know a lot of work goes on to try to do that. If you look at the suicide rates and the things that are happening out here, obviously it is still a problem.

I used to work at Medicare Local and we would do a men's health roadshow. I used to host it at Mitre 10 in the trade section, and men would go to that. Ours was actually the second highest attended in the whole region because men would go to something that was at Mitre 10. They would sit and have a beer and a sausage and talk but you have to tailor it to the people who need it. One size does not fit all. It is funny because something that will work in Nanango will not work in Kingaroy. There is not a blanket approach to mental health.

Dr ROWAN: Is there anything specifically that can be done in schools, particularly within the South Burnett region, to reach out to at-risk youth but also at the other end to strengthen those who are doing well? It is a combination of identifying, firstly, youth who need some specific mental health support or who might have some emerging drug or alcohol issue and, secondly, youth at the other end who are doing pretty well and then strengthening their resilience.

Ms Hams: We have identified that too. Even when we created the avatars with the young people, we asked, 'What does well look like?' You do not want to base everything on someone who is not well. What does well look like? What does healthy and happy look like? Again, it is almost like everything old is new again. Education is the key to a lot of the things that are happening here, and it is about starting when they are young. You cannot wait until they get to that point. You have to get into schools when they are younger. We talk about teaching year 10 students safe talks or mental health first aid so that they can be a mentor to the younger classes. Things like that are valuable. You do not want to target people who are unwell; you want the ones who are struggling to be mingling with the people who are doing well so they learn from each other.

Dr MacMAHON: Where would you direct LGBTIQ youth who might be facing mental health issues?

Ms Hams: That is an interesting question out here. I am not sure. I do not know if you have heard of the Red Ant Round-up Medical Conference. It is held biennially out here and it is something I organise through the PHN. That is one of our topics for next year. It is a tricky thing. Doctors are not always across all of that as well. Educating the GPs is probably the first thing. We do have a young lady on our youth council who has that as a particular interest so we will be looking to her for some direction with that. I know the schools have groups and things. That one is tricky. It is not new but we are the Bible Belt. All I can say is that we recognise that that is a gap and we are planning to educate our health professionals on how to work better with young people who identify with that.

ACTING CHAIR: There being no further questions, we will take a break and resume at 12.45. Thank you for coming in today. We appreciate your candour and your breadth of experience.

Proceedings suspended from 12.13 pm to 12.45 pm.

MARTOO, Mr Damien, President, Kingaroy Chamber of Commerce & Industry

SANFORD, Mr Michael, Counsellor, Principal Practitioner and Director, Bunyarra Counselling and Mediation

ACTING CHAIR: Good afternoon. I will invite you each to make a brief opening statement and then we will have questions from the committee.

Mr Martoo: Thank you for giving us the opportunity to speak to you here today. The Kingaroy Chamber of Commerce & Industry has been going deeply into mental wellbeing and mental health services within the region over the last 12 months through direct impacts to our chamber through people who have suicided. I myself personally lost my own son just before Christmas to suicide. This is a really important opportunity for the state government to see the impact mental health is having on not just the community but the business community as well and the flow-on effects into people's personal lives. It just does not stop immediately after you lose your child. This is a forever issue now not only for me but for my business community and my entire family. Whatever we can do, whatever information we can give to this committee today that they can take away and form some policy to improve the accessibility for people with mental health, not just suicide but all mental health in the regions especially, will be a benefit to everyone.

Mr Sanford: Similar to Damo, I would like to thank everyone for making the trip out to the South Burnett today. It is a great privilege to have all of you make that trip. I know it is a big time commitment for with everyone getting around at the moment to do these investigations and seeing where the barriers may exist.

Like Damo said, I work across both the private and business sectors. One of the biggest barriers we see in small geographically isolated communities like Kingaroy and the extended South Burnett is access to mental health services and the ongoing support that people need. I think it is a really great opportunity for all of you to be here today to hear our voices and get a feel for what we are facing and seeing on a daily basis.

ACTING CHAIR: I will begin by just letting you know, Damien, how very sorry I and every member of the committee is for your loss, so take your time today. I also want to flag that this inquiry has been designed as a trauma-informed inquiry. Should you find yourself feel vulnerable or in need of some extra support following your participation in the inquiry, Amanda from the secretariat can give you some information about services you can access. The last thing we want is to come in here in our investigation trying to support Queenslanders' mental health and leave mental health impacts in our wake, so please be aware of those opportunities should you need them.

I am going to ask the member for Nanango, as your local member, to start off with any questions. I know that she is a strong advocate for services in the region.

Mrs FRECKLINGTON: Thank you very much, Acting Chair. Can I as well put on record our community's sincere condolences to you, Bron and your family in relation to your loss. Thank you very much for the advocacy you do not only on behalf of the business community but the people of the South Burnett.

If I could start by talking about a positive that the Kingaroy Chamber of Commerce has put in place. Damo, I might get Michael to talk to this. In relation to how the Kingaroy Chamber of Commerce has supported the business community through your Smile program, could you give the committee a little bit of information in that regard?

Mr Sanford: Absolutely. If I can take you back a bit to the foundation of Smile. In 2020, as everyone is aware, we had the lovely word COVID make its way to Australia which impacted the business community significantly across the whole nation. I was very fortunate to be approached by a local company called Stanwell, who at that time had a lot of intermittent workers. We had back-to-back outages. We had families who were isolated for seven to 12 months at a time. There was an individual there—and it grew to a bigger party—who stated that we need to look at additional services rather than our standard EAP.

As a lot of you would be aware, face-to-face contact, relationship rapport, gets outcomes. If you expect someone who is in a challenged state or facing barriers to pick up a phone, ring a call number, get put on a waitlist and call back two days later, the successful outcome of that is not overly great. So we developed a program that initially started in the power industry and mining sector which put people on the ground. It saw an increase from 1.4 accesses a month to up over 40 accesses a month.

Mrs FRECKLINGTON: To clarify, is that just for this region?

Mr Sanford: That was just for this region on one site. We had almost 90 accesses in one week by putting a face-to-face counsellor on the ground, whereas the week previously they had zero accesses to any of their offered supports via telehealth services. It was very clear right from the get-go that face-to-face service in rural, remote and regional areas works. We always joke that country folk love relationship building, but it is genuine. It is true. Those who work in the mental health sector know that traditionally the demographics that are being reported are not welfare, not child safety: we are looking at everyday workers, students, tradesmen and farmers who are taking their own lives and struggling with mental health. These are often the ones who do not have the capacity to reach out and get support because they are normally working 12- to 14-hour days. They cannot get into town. They cannot drive 100 kilometres to access support. There is also a pride factor in reaching out and going to get these supports too, so a lot of this support is about reducing stigma and creating education.

We did training with the staff about awareness and response. I can safely say that, two years from that initial program, it is going stronger than when we initially started post COVID or the initial pandemic. We are seeing an increase still after two years of uptake. I was really fortunate that Damo saw what we were doing out at the mines. Unfortunately, there was an incident with one of our local businesses. A staff member who had tried to access EAP was put on a waitlist and unfortunately took their life before the EAP called them back. The chamber approached me at that time and said, 'We need to look at making a change. Tell us about what you're doing. How can we look at implementing that?' I will not go into it stage by stage because Damo can really sell that better than myself. I am very much about why we do this. I am very passionate about it.

What I can safely say is we launched a program called Smile at the start of last year which the family who lost their son is an ambassador for. They came along. As part of that we had over 100 businesses attend our initial launch for that practice. We have since been able to roll out education across all of these businesses around what is mental health? What is wellbeing? How do we respond to it? Where are the supports? What happens when critical incidents still occur? The uptake has been phenomenal because it is not just about education: it is about where do we go when things do not go right; being able to provide that resource to business owners around who to call and what to do.

Ultimately, it has saved lives. I can tell you right now that for one company alone we have done five suicide interventions where there was a plan and everything in place for that afternoon. That is just one company. Across all the broader companies in this area I cannot even begin to fathom how much work we are doing. Traditionally EAP for us is like parking an ambulance at the bottom of the cliff. They respond when the incident has occurred. The current system out here is not resourced to handle the uptake of the mental health challenges we face on a daily basis. This is about developing strategies we can target in a community capacity to try to achieve an outcome before we even get to the edge. It is about removing that cliff altogether and having that pro-active response.

ACTING CHAIR: If I could just ask you, please, Michael, to break down for us a little bit how that is different to what you provide to a conventional EAP service. How is that experienced on the ground by people who are accessing that service?

Mr Sanford: When you ring the number you get the same person every time. When we work with a business we do not provide a 1300 number: we provide a direct mobile for that caseworker who is supporting that business. For example, as a counsellor we have to access supervision every month, and ringing someone to have that is one of the most horrible experiences I will have ever as a practitioner, because there is nothing more uncomfortable than exposing your vulnerability on challenges to a different person every single month and having to relive the trauma of what you may be experiencing in your role to a different person every month. When you have a relationship and rapport, it makes opening up and discussing situations that much clearer and that much simpler.

What we have established working with these businesses is that I might have a relationship with a particular company. If there is a challenge they call me, I answer, we respond, we get an outcome, hopefully straightaway. I will happily admit that my colleagues and I have been registered as an EAP provider. We removed ourselves from that after knowing we get referrals 48 hours after a person has disclosed there is a serious condition or a serious situation occurring. They have either taken action or they have been able to resolve it. There is no point having a wait time. It is about the right response at the right time to get the right outcome.

It is about you knowing me. There is a stigma about counsellors, psychologists and psychiatrists. People avoid us because we are the weird ones you talk to and expose everything to. It is about removing that title. In your role as an MP you want people to know who you are, what Ali

can bring to her community. It is exactly the same as what we are trying to do. We are trying to remove the barriers that are our labels as practitioners and going, 'I'm Michael and I'm here to help you. This is my other practitioner for the business. They're here to help you.' It is not a referral to a psychologist. It is not a referral. Most of the time we are not even doing referrals.

I am sorry, I should step back. I am on the ground in most of these businesses on a weekly basis. For example, after I finish here today I am off to Brisbane, up to Rocky, up to Townsville and back, because they are the businesses I support. Rather than wait for things to get bad, I will go onsite for one to two days and I will be present. I will engage people on their level in the place where they feel safe and secure because we know that is where the outcomes are. For example, I feel nervous coming here and talking to you today because this is outside of my comfort zone. I can guarantee that if this was in my office there is already that power imbalance because you are coming to a place where your comfort does not exist. Knowing that people feel comfortable in their workplace, that is the best place to get results because we are there engaging them on their level where they feel safe.

Dr MacMAHON: Thank you both for being here today. We heard a little bit this morning about the economic impacts of poverty and unemployment, but on the other hand it sounds like you are facing people who are overworked and really struggling. I wonder if you could unpack a little bit about what the business and industry community is facing here that could lead to mental health issues.

Mr Martoo: Yes, absolutely. Obviously COVID is a major contributor. I think before that it was the 10 years of drought this region faced. Whilst it does not directly impact business, it comes from a second tier where the agricultural community is not making money, then they do not spend money, so we are seeing people tighten their purses and that sort of thing. Coming off the back of COVID now is the increase in costs, the inability to get staff, the overworking of staff, staff being out of the business because they are close contacts for up to six to eight weeks. It just keeps rolling on.

This keeps exacerbating. Then when a consumer comes in and starts abusing a business owner or a staff member, who is generally a junior staff member, for not being quick enough in serving them, that starts escalating. You are concentrating on running your business and providing a service and then you have this on top. You are not sure whether your overheads are going to increase today and then exponentially to 30 per cent tomorrow, and the quote you have just given to someone is now going to be 100 per cent more because the cost of that piece of steel has gone up 60 per cent overnight—this is what we are facing. You might think some of the strongest people can handle this, but it is getting to the point now that we see this really targeting business.

In the last CCIQ Pulse Survey 65 per cent of respondents said that either themselves or someone in their business is struggling with mental health. That is huge, and that is across the state. I chair the Wide Bay-Burnett regional policy committee for CCIQ and I sit on the policy board. To hear that from businesses across all sectors, whether it is agriculture, the food service industry or a car dealership—it is everywhere. People are feeling insecure about their jobs as well. They are asking, 'Am I going to have a job because we cannot get stock in?' They take that home as well. We talk about people with little money, but these people are earning anywhere between $60,000 and $200,000 a year. They are still suffering because of the uncertainty they face.

ACTING CHAIR: Could I ask you about the role of your local Chamber of Commerce in supporting the community's mental health here? What initiatives have you embarked on in that space?

Mr Martoo: This is where SMILE came into it, when an executive member's staff member suicided. We decided right there and then as a chamber, after we had done some strategic planning, that our role is not just about business; it is also about community. Everything we do has to support the entire community.

When we introduced SMILE—and Michael was a big part of that—the first step we took was to introduce the NICL training. It was called Notice, Inquire, Connect and Link—NICL. We put that out free of charge to our members. We got some extra funding through our RRR and now we are extending that out to the wider community. That was the start of businesses saying, 'Okay, I have a responsibility as a manager or an owner to make sure my staff is okay.' We saw from that initial round of training that small to medium enterprises were ringing service providers saying, 'Hey, I have this young man here who is spending all his money. He is an apprentice. I think he's doing drugs. Can someone come in and talk to them?' That one initial contact onsite has kept that young person off those substances, he is saving his money now and is continuing his job so he can finish his apprenticeship. These are the small steps we have taken in that area.

As the Kingaroy Chamber of Commerce we have now partnered with CCIQ; the Mental Health Commissioner, Ivan Frkovic—and he has been a really big ambassador for this program—and Maree Adshead from the Small Business Commissioner's office to send this out statewide through chambers of commerce. It will come under the umbrella of SMILE—and NICL is one part of SMILE, as well as walk-and-talks and mentor programs. Then other chambers can add their own ideas to it.

Our next step in this is setting up a fund—this is probably the biggest part—so that if a business owner has someone who needs trauma counselling straightaway, they will call a service provider in the region. The service provider will attend that trauma counselling and they will send the chamber a bill. We will pay it because money seems to be a real hindrance. No matter how much people earn, they think, 'Who is going to pay for this?' They do not have to worry. They are then in the system. On a personal level, we have seen that once you are in the system you can access services more easily. That is our next step: setting up that fund, and I think we are about three or four weeks away from doing so.

That is where we are at currently. This is being done by volunteers. We are all business owners working in our own business and now as a volunteer organisation we are implementing this slowly over time. We see a benefit for it. As Michael said, we hope we can be the safety net at the top of the cliff, not the ambulance at the bottom.

Mrs FRECKLINGTON: Hopefully we can get the SMILE program right across Queensland. I would really like to ask you for a professional's point of view about the provision of mental health services based here in Kingaroy, be that issues around paramedics and the wait time or the provision of services in our local hospital.

Mr Sanford: You probably hear complaints all the time about Queensland Health and the mental health services that are provided, so I will not ramble on too much about that. I will give you some specifics that have caused a lot of challenges for me as a practitioner. It was only about a month ago when a business in town reached out to us because they had a suicidal employee. Upon arriving at the workplace, they had already started harming themselves with a knife. They had a plan in place and everything in place to carry out their act of suicide. We rang triple 0 and sat with the client.

We got a little bit distracted in terms of the time because we were obviously de-escalating, supporting and ensuring safety at that point. Two hours had gone by and a paramedic had still not responded. I rang triple 0 again and was told that the likelihood of getting a paramedic there to deal with the suicidal client was pretty well non-existent at that time. They asked if I, as a private practitioner, could please transport them to the closest emergency department myself. Anyone who is in that industry would know it goes against all ethics, policies and procedures to transport a client, but that is the level we were at. That client was discharged within an hour of being at the hospital and was straight back into the same situation upon being discharged.

In another case I had noticed a young female apprentice at work who appeared to have some kind of injury behind her clothing due to what looked like fluid leaking through her work pants. Upon further investigation with the female nurses, she had actually hacked significant wounds into her legs that morning before work and had planned to suicide either at the workplace or on her way home from the workplace that afternoon. We called triple 0 and were fortunate enough that an ambulance did attend that site that day. She was transported back to Kingaroy at which point we were told there were no mental health staff onsite and the likelihood of getting someone to come and assess this individual was very low. At that point they had to do a phone assessment for that individual. They asked her what the likelihood was that she would commit suicide. Her reply was, 'If I say I'm going to do it, what's the outcome?' They replied, 'We will look at keeping you in for further support.' She said, 'In that case, I'll do whatever I have to in order to get out of here and I won't hurt myself,' to which they said, 'No worries,' and they ticked a box. Both myself and the doctor who was on at Kingaroy Hospital that night were obviously in a little bit of disbelief due to the horrific injuries. All they could do was treat the physical injuries and release her, which again puts duty of care back onto me as a treating practitioner.

Mrs FRECKLINGTON: Does the doctor have to sign off on the release to leave hospital though?

Mr Sanford: The doctor was overruled by the practising physician from the mental health team.

Mrs FRECKLINGTON: The mental health team is not based here in Kingaroy?

Mr Sanford: Correct.

Mrs FRECKLINGTON: That is based—

Mr Sanford:—out of Toowoomba I believe.

Mr MOLHOEK: Is it fair to say also that under the Queensland health system if someone says, 'I want to go,' or convinces the doctor they are okay to go, they cannot hold them, either?

Mr Sanford: That is correct. They physically cannot hold them against their will. Part of the system that we are struggling with now is that the community is educated on being able to exit that system because of the fear of what is to come afterwards. The problem in that situation is we have a statutory level system such as Queensland mental health that does not actually exist. Again, for private practitioners, we take the risk of burning out private supports because there is literally no-one else to respond to it. I believe there are three staff who are fully employed at Queensland mental health for Kingaroy. At any one time in the past six months there has been only one person on due to COVID, illness, burnout—for whatever reason—

Mr MOLHOEK: Vacancy.

Mr Sanford:—vacancy. It has made it very challenging. As a private practitioner I can spend seven to eight hours of my time trying to support a client there because there is literally no-one else who will support them for a mental health issue.

Mrs McMAHON: In that vein, through the private system, through the workplace or through the public system, if someone has been assessed as needing admittance as an inpatient and the assessment supports that, what does that look like for a local here? Where would they be going as an acute patient?

Mr Sanford: Toowoomba.

Mrs McMAHON: Generally what does that look like in terms of the impact if Toowoomba is the closest inpatient bed?

Mr Sanford: Obviously we have displaced people being relocated to Toowoomba. The problem is we do not even have the opportunity to look at what supports can be put in place if that person does go there. Part of the language we are seeing in hospitals is a lot of that negative language around, 'If you go there, these will be the challenges you will face.' It is almost like we are talking clients out of receiving the support that could potentially be beneficial for them. Do not get me wrong; sometimes institutionalising or putting someone in a situation can obviously escalate and create a further problem, but when we have such high suicide rates in our community it just worries me sometimes that we are going to miss the next person who could become another statistic.

Mrs McMAHON: In this committee we often hear about the 'missing middle', that is, those who need more than just GP support or localised counselling support but do not need hospitalisation in terms of being an acute patient or taking up a bed. In a regional area like Kingaroy or South Burnett, what would a facility or service look like that catered to that missing middle? How would it need to function, who would it need to be staffed by and what role do you see for a peer workforce?

Mr Sanford: I think we have done the peer workforce previously with PHaMs, which is that Personal Helpers and Mentors program that I believe was pretty successful. Again, we are only targeting a certain demographic of people; we are targeting the people who normally are not at work, the people who have the capacity to go to services such as CTC, who spoke this morning. What you will see from the different services is that CTC will give you a good cross-section of the individuals who are either referred or mandated to attend an NGO. One of the gaps that we are missing are those farmers, employees and students because a lot of the time these individuals are not seeking that support and are not able to engage with a program like PHaMs.

I cannot give you a quick fix. I think mental health has become so large across the whole nation that we need to look at going back to grassroots. During COVID and previously we looked at how can we become the most efficient at delivering services, which actually removed people from the ground. Instead, we went to phone based, back-to-back sessions and, in doing so, we removed connection which is when a lot of the issues started coming up.

Mrs McMAHON: If we had the magic bucket of money and said, 'You can have a facility that is not a hospital but provides more support than you can get from your GP,' what would that look like here? What would it be catering to? How would that be structured? How would someone access it?

Mr Sanford: I would like to go 10 steps further back and instead of looking at an institution, look at a service that is on the ground, engaging with people on their level before they get to that point. When we know that people are already struggling, engage with them in their early struggles. Do not engage with them when it is already at that point of snowballing into such a large situation. I would be looking at putting social workers, psychologists, counsellors plus peer support workers on the ground in some sort of central hub, a place where people can reach out and go but a place where those practitioners reach out back. It is not just relying on people to come to the support; it is looking at the support going to the people.

ACTING CHAIR: We certainly heard a lot about the importance of those reaching into community services in the course of our travels across Queensland.

Mr MOLHOEK: Are you aware of Ryan's rule?

Mr Sanford: I am aware of Ryan's rule, yes.

Mr MOLHOEK: On that occasion would it have been appropriate to have raised that?

Mr Sanford: Absolutely. The problem is we cannot coerce or influence a client to make a decision. Ultimately when they are put into a situation where maybe it is not ideal for them and they are already feeling frightened, it is already a challenge to educate people to say to them, 'If you're not feeling great and you think you're a risk to yourself, you need to tell us,' when the people they are meant to tell are saying, 'If you tell us you are at risk, this is going to happen.' I hope that answers the question.

Dr ROWAN: I wanted to follow up from the member for Macalister because I think that this is a really important point about identifying that missing middle. What I mean by that is we had a psychiatrist who said to us that not all suicidality is as a result of mental health disorders or harm and that suicidality really needed to be treated as a stand-alone, specific condition. When it comes to areas like Kingaroy where you might have a farmer with financial stressors or there might be a relationship breakdown or unresolved grief or a uni student who do not pass an exam—all of those people can suddenly go from seemingly in a situation where everything is okay to being in an acute crisis situation.

How do you have that early identification and immediate intervention based on that sort of model across all of those demographics? There could be a farmer who is 60 years of age to, at the other end of the spectrum, a uni student who is 18 or someone who has had a relationship breakdown. How do you have a service in the South Burnett that is engaging across all of those demographics and having that early identification and then immediate intervention to give them the support and, as the member for Macalister said, where does that sit? Then how does it coordinate with other services? If you take someone like that and you immediately put them in hospital into a mental health ward, there can be a traumatising experience from that as well.

Mr Sanford: Correct. It all comes back to whatever is set up, created, implemented, it needs to be from a purely proactive approach. It cannot be reactive and responding to an incident or a negative outcome. It is about getting out and developing relationships early on. All the success we have had has been because people feel comfortable and trusted to say, 'Look, I have had a really crap morning. This is how I am feeling about it. What can we do?' Putting a simple practice or some kind of therapeutic response in place for a minor challenge is a lot simpler than allowing that situation to escalate and snowball for six weeks because they were not sure where to go or what to achieve.

My apologies; I will try to make sure I stay on track with what you are saying. For me, it has to be that the person or the program has to be out there with the people. Too often we are trained as practitioners to sit in our office because the most effective and efficient way to work is one person after another comes through that door and we do whatever we can to get as many people through, but ultimately if we can have more people on the ground and have them out in the community seeing the farmers, seeing the workers, seeing the students, you are straightaway creating a connection or a network for where they can reach out to should times get tough.

Dr ROWAN: Are they embedded in schools, community organisations, Rotary, farmer organisations, the business sector?

Mrs FRECKLINGTON: Who employs them?

Mr Sanford: That is going to be the fun debate. Absolutely, it certainly is not easy.

ACTING CHAIR: This is the $64,000 question.

Mr Sanford: You will get every NGO and service under the sun come to you and say, 'Give us some money and we can change the world.' That is not always going to be the case. I have worked for the NGOs locally and they do absolutely amazing things, but unfortunately there are always going to be grey areas when it comes to contracts and funding. I cannot give you the exact answer for it. I know at the moment there are a lot of us who are busting our butt, to put it nicely. I know for our business already we have given up $20,000 worth of free services to the South Burnett already for the year, responding to crisis in community, doing some sort of response because there is nothing else that exists. Because you are out and about, because you go to all the different activities, people see you. I always make a joke that people know me as the bald-headed bogan counsellor of the South Burnett, but at least they know me. If they know someone, they reach out.

I panic when I go down to Brisbane and the Gold Coast because there are so many people. There are so many situations. I did a little study one day—I should not say 'study'; that makes it sound like it was actually factual or feign fancy: I walked down the street and I made it my mission that I was going to engage with as many people as I could, and the only person that engaged with me was the one running away thinking I was a creeper. In the community, we do not have to worry about that because people are a bit more connected, but down in the city I think sometimes they go, 'We have a lot of services and it is great.' People will connect and they will reach out, but, again, you have to explore what the outcomes are like because with connection and outcomes, there is a massive correlation between the two.

That is something that we noticed here. In our first SMILE training, we stood up and said, 'Tell us all the providers that work for mental health in your community,' and we had 16 or so listed on a pamphlet are meant to outreach to support the South Burnett, and two were named. These are from professionals; these are people who are actually employed in the capacity to work in our community to support people. So if the professionals who are meant to be educated do not even know where to get help, how do we get the help for the people who maybe do not know where to reach out?

ACTING CHAIR: I want to ask a question of Damien, if you would not mind, and I ask this knowing from my own experience that ripples over decades of having somebody close to you who takes their life. Could you talk, perhaps generally or more specifically, about what kind of support is needed in a regional area for post suicide, whether that is a suicide that was violent or whether there has been attempts, for that person and their family? What do you think would be most useful?

Mr Martoo: I will talk openly about Jack's suicide. He lived in Brisbane. He was a very clever young man, 23 years old. He worked for a compounding pharmacy. He was the manager of a number of labs. He had doctors working underneath him and he still had not finished his qualifications. He was researching mental health and how he was going to pass that onto his own children if he was to have children. We never saw this coming. There was absolutely no indication that this was going to cross his mind.

After Jack's suicide, after we got that phone call on 14 December, when Christian, my other son found him, we drove to Brisbane. It took us four hours to get there—the longest four hours of my life. That afternoon we got a phone call from a service provider called Standby, funded by the federal government and also Uniting Care. That is the only official support that is available at this point in time that is delivered to the immediate family and the person who finds the person who has suicided. They contact you straightaway. They come and visit you. Then they will contact you three, six, nine, 12 and then 24 months after the suicide. Their service is fantastic. They do help you access support. We were very lucky. We were lucky as our family was already in the system. My twin daughters suffer anxiety and have been seeing a counsellor for two years.

When we came back from Brisbane, after we had spoken to Standby, our GP rang our counsellor and said, 'You need to see these people. This has happened.' We were able to get in there straightaway and see them, only because we were already in the system, and we continue to do so.

My other son, Christian, who found Jack, initially did not want to see or speak to anyone. He finally came to the realisation he had to deal with his trauma and the flashbacks of finding Jack. It has taken two months for him to find a psychologist in Brisbane to speak to. His GP gave him a list of providers; there were about 30 in Brisbane to contact. Here is a young man with ADHD who has just found his brother dead and they expect you to have the mindset to go through a list of people and their locations to say, 'Hey, I need help.' It just does not work. I took it upon myself; I did the groundwork for him. I happened to ring a service provider and they said, 'Christian is not in our zone,' because they were in Strathpine and he is in Bracken Ridge, 'but I do know this one young lady who has worked for Queensland Health and she has gone out on her own and is taking new patients.' That was another four weeks. It took him three months. He is 28.

As soon as someone in your family suicides, everyone—immediate family and friends—are now at extreme risk for life of suiciding. It was at that point I realised that there is a real issue here with the after-support and young people seeking support as well.

Because of COVID and the lockdowns, the second last time I saw Jack was when I took him out to dinner in April last year before the Small Business Friendly Council's conference, and then the last time I saw him was in September last year for about five minutes because he was getting up to go to work and we just happened to be in Brisbane. Due to his work commitments, lockdowns, because he worked in the compounding pharmacy industry with all that stuff going on with COVID, we never saw him, so we never saw those initial changes. If we had people on the ground where people were seeing the changes, I am not saying it would have saved Jack—I think if someone is

going to suicide and they are serious, they are going to do it, no matter what; there will be no sign. We are never going to save everyone. That is the only service that I know of, and that is initiated by the Queensland Police department.

The other issue that comes on the back of this then, after a suicide, is the issue with the coroner. We were lucky with Jack that we were one of the 30 per cent of people who gets a suicide note. We were told we were not allowed to have that note because it is sitting on the coroner's desk and they need it for their investigation. After a couple of phone calls and calling in a favour of our local senior officer-in-charge, we were able to get a photocopy of that note because we needed answers as part of our healing process. We are still waiting, and we will probably wait another three or four months before we get an actual report from the coroner on Jack's death.

We are now back to the point of starting to heal. My wife has started work again yesterday. She is a teacher. She took the first term off. We will now get a report from the coroner and we are going to go back into a slump. That is not good enough. That information needs to come in quickly. We know what the mechanism of death was—that came back in from the coroner's initial report for the death certificate—but the full report will take up to six months. Families should not have to wait that long. We are now waiting. We are still waiting for the original copy of Jack's suicide note. This is the last letter our son wrote to us, and you can only imagine what he was thinking that night that he did that.

The issue is with the entire system is not just with the service providers. It goes all the way through, even to the phone call we had from the John Tonge Centre where Jack was first taken for initial autopsy. The physician there said, 'I do not think it is a good idea you come and see Jack because of the way he looks from the mechanism of death. Jack hung himself. When you hang yourself, your tongue protrudes.' We did not need to hear that. We did not need to hear that that is how our son looked.

Luckily for us, our local mortuary staff were able to manipulate Jack's tongue into his mouth so that when we first got to view him a week later he looked like our little boy sleeping.

It is these sort of processes we need to actually add in place after someone suicides to ease the pressure on the family's mental health. We are lucky we are quite a strong family unit. My wife's niece suicided 20 years ago. This has raised issues again with our entire family. It is all these little things. It is these policies that need to be put in place in that situation. Those physicians deal with it every day; it is nothing to them. But for a family who has lost a child to that sort of mechanism, to hear that—man, I am a pretty calm person, but that really riled me up, and it riled up our local funeral service as well, saying, 'There is absolutely no need for people to be saying that to you.'

ACTING CHAIR: Thank you for sharing that. It is really personal and it is really appreciated.

Dr MacMAHON: Michael, I am really interested to hear your comments around the importance of that face-to-face connection and building those connections. Telehealth is often put forward as a bit of a panacea for services, particularly in the regions. I wonder if you could talk a little bit more about, in your professional experience, why that professional connection is an important part of a therapeutic process.

Mr Sanford: Absolutely. If you look back at our basic biology, humans in general are a social being. We require social connection. It is just an everyday part of who we are. Taking away that connection takes away the ability to be vulnerable. I know with what Damo has gone through and we see it on a regular basis, the people who have to access support services do not actually get the opportunity to grieve openly and completely about what is going on because it is a self-protection mechanism that we have as people. I have been there myself as an individual. How often are you in a position where someone says, 'Tell me what is going on,' and you skate around the truth? You rationalise. You stay up here in your thought process; you do not get down here in your feeling process because this is scary. As adults we do not like to feel, we like to think, because we can rationalise, protect ourselves and create a scenario and reason for what may be occurring and why.

The face-to-face stuff allows us as practitioners to get to know who Dr Amy MacMahon is. Like I said before, it is about that who are you and who am I? This initially came about (a) not just to make sure we can outreach, but as counsellors, psychologists, psychiatrists and so on, I think all these amazing policies were created to try to protect us from vicarious trauma. So by having that one step removed, too, that connection protects us as individuals, but in doing so, I do not think we achieve the true outcome of what we are trained and employed to do.

I never ever would want to go through what Damo has gone through and what we deal with on a daily basis. I can see today like how vicariously you as a team feel hearing that story. You avoid feeling that sort of stuff because it makes you uncomfortable, but the thing is, too, sometimes we

need discomfort to heal. We can relate to that. We can connect to that. It becomes real, and real is actually how you get that result. I would hope that Damo would always be able to have that face-to-face support because I think there would be nothing—without trying to talk blunt or rude on the microphones, if I ever got told what Damo got told by a coroner, I think he held himself together very well. He should not have to be told that sort of stuff, but you should also then never have a counsellor ring you and say, 'Tell me how you feel?' How do you know that they are actually engaged? How do you know they are interested? Crikey, when I had supervision, I used to put the phone next to my ear and continue doing case notes and I would pretend I was actually in the supervision. If I am doing that when I am meant to engage, what are the other people on the end of the phone doing to me?

Part of being a counsellor in our role is not actually the words that come out of your mouth, it is about what is going on for your body, what is going on for your tone, what is going on with your facial expressions. It gives us the ability to read the situation where the genuine feeling of hurt and pain is coming from. I can sit here and say, 'I am so crappy today' with a different smile on my face. It is understanding what the context is. It is about knowing who the person is you are talking to.

ACTING CHAIR: I will pause and note for the benefit of the committee that our follow-on submitters have not arrived due to illness, so I want to check in with both of you to see if you are prepared to provide a little bit more time for the benefit of the committee.

Mr Martoo: I am okay.

Mr Sanford: I am okay, too.

Dr ROWAN: Damien, thank you for sharing what was a very traumatic and difficult experience. One of the things I took away from it, and I am saying this delicately and sensitively as well, is there is a lot of people through that process who seem to lack the empathy, the compassion and the understanding for what you and other members of your family have been through. It is almost like a further traumatising experience. You have the trauma, but then you have a further traumatising experience. Have you any thoughts, having been through that, about how that process can be managed better? In other words, you obviously need to have education for a range of people to have that compassion, empathy and understanding, but in a system way, as you are a very knowledgeable person and there are plenty of other people out there who may not have had as much experience, but how do you ensure that people are not further traumatised through the process, but they get the supports that they need as well along the way? With the complexity of what your son Christian needed, what you needed, the process of the coroner and all those people, how do you help a family and extended people throughout not only the immediate things you are dealing with but also in the longer term as well as a whole?

Mr Martoo: Yes. I wish I actually had an answer to that. I think it comes back to policy. I do not understand how the medical board works, but I would just assume—and I guess this is what I spoke about quite clearly with Jason from Virgo Funerals—that when a young man comes into the John Tonge Centre through suicide and there is something that does not look quite right and you ring a family who are quite obviously traumatised on the phone, you would start questioning yourself, 'Do I tell them about this?' We had asked the question, 'Can we come and see Jack? We want to see him.' I think it comes back to training. I think it comes back to policy within that institution to say, 'Sorry, we are not able to have people in at the moment. It is probably better that you wait until he comes back to where the funeral arrangements are taking place.' Look, that is what I would say when you are dealing with someone through such trauma. Mind you, this was 24 hours after we got the phone call that Jack had suicided.

As a chamber of commerce president, we have policies in place when we do stuff to make sure we are not harming anyone in any way and doing the best for our members and the wider community on a volunteer basis. If a big organisation like Queensland Health cannot set policy in place for that sort of thing, there is a real issue. Where that comes from, I do not know.

Honestly, it should be part of training. Jack was training to become a chemist or a doctor to work in Indigenous health. We knew he had no bedside manner—he was a top bloke, but no bedside manner—so he would work in research. That was just Jack. That is why he worked so well in a pharmacy: he just had his little booth and he could just go in there and did not have to talk to anyone.

I think it is about training and it has to be ongoing training. When I start to talk about mental health and wellbeing, I try to step away from suicide because this always goes back to suicide. We need to talk about it as a whole. With every policy that is put in place, we need to start thinking about how we are interacting with other people. I know that people flippantly say something like, 'Oh, I would

just die if that happened to me.' I cannot even say that anymore. You know, 'I could just kill myself if that happened'—you start to really knuckle down and think about the way you use language because you do not know what someone has been through. I have 15-year-old twin girls—they had their birthday on Saturday—they still say it: 'Oh, god, I am just going to kill myself if I have to brush my hair this way again!' These sorts of things. They do not understand. You take it with a grain of salt. They do not mean it, I know that, but it really gets into the heart. However, at the initial trauma stage, I think there needs to be ongoing training with how those frontline workers are dealing with family.

Mr Sanford: I think half the issue—and this is similar with mental health and domestic violence—it is starting to become so normalised and we are desensitised that we are not shocked. When we are not shocked we can disconnect so we can remove the emotion. Therefore, similar to what Damo has had to experience, you have a person who has been so significantly exposed to the situation, they do not connect the empathy of the actual act to the person, so they just tell the facts and figures. The problem is we all still need to be shocked which is probably not great for our own wellbeing, but by being shocked, at least we act in a way that is empathetic and understanding to people around us. We do not treat it like the norm because when it becomes the norm, we stop acting to try to create change. It is trying to get people to realise that change is still needed, not just going, 'This is the situation.'

ACTING CHAIR: Michael, what role, if any, do you see for mental health first aid training for community members? We visited the site of Mates in Construction and they seem to have their own very particular mental health first aid approach.

Mr Sanford: They do.

ACTING CHAIR: However, we have also spoken to the Red Cross in Cairns who delivers a mental health first aid training into Townsville women's prison to skill up inmates for mental health first aid for them to use within their prison community. Do you have any thoughts about the value of that or otherwise?

Mr Sanford: I think mental health first aid is great training for everyone to participate in, but it is also really important that it is not every individual's responsibility to respond to mental health because then we have the risk of vicarious trauma and an increasing mental health concern. Part of what we do with the training is pretty well mental health, but the final section of that is that link which is empowering people to find that support, whether they hold the hand or they dial the number because it is not up to them as an individual to be that person. We know—and I am sorry if I swear into your microphones—that in Australia we have this great little thing where we do a couple of things. I walk up to you and I say, 'Ali, how are you doing?' and you say, 'Not great,' and I go, 'Oh, shit!' I run. Sorry if that has to be struck off. Or we do the second thing where I say, 'Ali, how are you?' and you already know or you are concerned that my reaction is not going to be positive so you say, 'I am doing well, thank you,' but you are not. We are afraid that if we take on that burden of someone else we will not know what to do with that burden, so we avoid it. I think if we are going to do mental health first aid, we have to make sure that there is a follow-up service or support so that individual does not feel like they have the responsibility and duty of care of saving someone's life.

ACTING CHAIR: Thank you. That is helpful.

Mrs McMAHON: Can I ask a follow-up on a comment you made before about the need to have empathy and particularly for those people who work in that space. Throughout the committee's hearings, we have heard from representatives who are first responders—your police, your ambos and your firies—the people who rock up to traumatic events day in, day out, and that level of disassociation that they professionally put on in order to be able to be confronted with those jobs on a daily basis. I am wondering, in your opinion, having probably worked with people who have obviously been engaged with police and vice versa, how does a first responder balance the need to be professional and themselves not break down at every single job, yet still have the interpersonal skills? It is a big ask.

Mr Sanford: Absolutely it is.

Mrs McMAHON: How do we train those first responders to be nuanced to the situation?

Mr Sanford: I think all we have to do is look at the fallout rate from first responders 10 to 15 years down the track. What we see is a high increase in the decline of mental health or access to mental health services for first responders because they try to compartmentalise and disassociate from what they are actually seeing. We see that come out in some other behaviour later on down the track because of lack of seeking support. My view is a further education for those systems in place to ensure that that support is being implemented.

A lot of the people that we have worked with, and the best part about Kingaroy, is that we talk to the police, we talk to the ambos, and that is not something that is overly encouraged. It is not something that is overly provided. Perhaps if we started providing it and we reduced the stigma around accessing support, we might see people who do not have to disassociate and they can actually be empathetic in that moment.

When I talk about empathetic, I am not saying that you break down and cry. There is still a level of professionalism in being able to deliver your job, but it is okay to walk away from a job and go, ‘Wow, that actually hits,’ and when that hits here and you have a feeling for that, talk about that.

We look at things like QPS which has been a male-dominated area of work for a long period of time. We also started going into that man box where we go, ‘I am man; I am not vulnerable. I do not show emotion. I do not cry.’ So then we have created a place of employment where part of that stigma is, ‘I am a police officer. I am strong. I am not vulnerable.’ There is almost some form of masculinity, no matter your gender, about you have to be tough. Whether you are QPS, whether you are an MP, whether you a person on the street, people feel. It is a part of what happens. When you feel, it is about getting those supports at that right time—when you do feel.

Mrs McMAHON: Can you say that you have noticed a difference between first responders, police officers, who work in country and rural towns versus those who work in urban areas or when they come out here from the city for the first time?

Mr Sanford: Absolutely.

Mrs McMAHON: The way that they approach and deal with jobs in a smaller community versus the anonymity of the city is starkly different.

Mr Sanford: It is not even about being anonymous within community: it is about the fact that we have a certain number of police officers and quite a large number of bad things happen. In the city there might be a bit more rotation around dealing with trauma, whereas out here if you look at places like Kumbia, Blackbutt, Yarraman, Cooyar and all of the surrounding areas, we have one police officer, so no matter what bad thing is happening in that town you have one copper. I had family in the Tassie police. My first ever job was with the Tasmania police as a little cadet. I know firsthand that all those people make out it is okay, and then you see all the behaviours come out in another negative manner because they have not dealt with the initial cause of what that situation may be, which is trauma. Trauma displays in so many different ways.

Ms CAMM: Damien, thank you. What you are speaking about is system change, and other members on the committee have outlined trauma-informed system change. I want to commend you because I think you have given testimony today that reflects what so many families in Queensland have never had the opportunity to share. The story you shared today is the story of my father 12 years ago when he hung himself. The situation with the coroner and all of that is exactly the same. I think you have shown enormous bravery to speak on behalf of families who have experienced suicide, so thank you first and foremost.

My question is to Michael around what I have heard when we travelled to other regions. As you were explaining, you now travel to Townsville and other regional communities. It was really important that we come to Kingaroy. We have been to Cairns but we have not travelled to too many regional communities. We talk about place-based, co-designed models. In your own words, can you tell us how that looks and feels? You said earlier that you could throw buckets of money to NGOs but the outcome may still be the same. What do you think makes regional and rural communities different? If you could just look at a systems change model, who would you empower to design that?

Mr Sanford: I would empower the community. You need to get back to community development. One of the biggest things we lack as professionals nowadays is sitting in and listening to what is needed. We all come with grand plans and think we know what is needed, but often we miss the whole point. One of the units I did at uni was about community development. There was a little town, I think it was in Papua New Guinea, and suddenly there was a massive outbreak of chlamydia. All of these professionals went in and said, ‘We’re going to teach safe sex and we’re going to provide you with protection,’ but it never resolved the issue. Then they sat with the community and found out what was wrong. All of the men used to take fruit and veggies into town of a morning and they used to come back in the afternoon. During a storm a bridge was washed away, so instead of the men being able to walk there and back in one day it meant they had to walk there and stay the night—which is when all the issues would happen—and come back the next day. I am not going to quote on record how much they invested because I will get it wrong, but they invested a large sum of money to educate on safe sex and provide all of this protection, whereas if they just went in and listened, all they needed was a bridge repaired. It would have resolved the situation.

I know firsthand in my younger years when I still had hair and whatnot I would go in as a young councillor and be like, 'We can change the world! We can do this and that.' But that is not what people needed. People needed someone to sit in it so they could experience what they were going through. I think the only way to deliver a model that would be effective and efficient in a community such as this is actually spend time sitting with the community to find out what is needed at a community-based level—which is still going to vary. In all honesty, it is. You are going to get different opinions. But the one thing we have seen and the biggest success, whether it be the Kingaroy Chamber of Commerce, whether it be Deb's role, is the more pro-active and the more present you are here, the more likely people engage. It is just guaranteed with community. I do not know how many times we have had organisations come here and preach about how they are going to change the community. They try to deliver something and it is never well-received because the community go, 'We don't know you. We don't know who you are, what your intentions are, what the whole plan of this program is.' When the relationship is there people are like, 'All right, we'll give it a crack. We'll see what this is about.' They become invested at a community level.

ACTING CHAIR: Member for Nanango, do you have a question?

Mrs FRECKLINGTON: No, I do not think I can ask any more questions because that was such a wonderful way to end, Amanda. My question was going to be to you, Damo, but Michael might be more minded to answer. You talk about the age of your children. We have met some young men today who work for CTC who provide services to youth. Are we missing something in our high schools, or is the service there but we just do not always have the ability to access it for our children?

Mr Sanford: We are not allowed to use the word 'suicide' at schools. Schools are afraid of it. There is this stigma that if we talk about suicide we create suicide, but ultimately if we do not talk about something we create more stigma, which then means it happens behind closed doors. We need to eliminate the stigma, whether it be in schools or communities, and have open communication. It should be a topic that we can discuss and really dig deep and explore.

Mr Martoo: My wife is a teacher. I think the issue is we always go, 'We need to add it to schools,' but the curriculum is so full nowadays there is no time for students or for teachers to scratch themselves. I think there is a place for education around mental illness in schools. Headspace comes in here quite regularly and does a great job as well. I guess the area I struggle with is how do we get people to connect? How do we make it okay for people to talk about this? My experience in the past five months is that initially I would avoid the subject and I would avoid people. Having to wear masks was probably the best thing that ever happened to me and my wife because you could put your cap on and hide a little bit. It is just about being open and honest and to know that, it does not matter who you are, what you are or what you do, it is going to affect someone. Mental illness can affect anyone.

I really struggled when Jack did suicide because, here we are as a Chamber of Commerce working really hard to support people through mental health here in this region, and I let the ball drop on my own family. Was it my fault? Yep. Was it everyone's fault? Yep. Initially, really, it was Jack's fault. He decided. We have sought spiritual help. Jack's girlfriend is a beautiful girl. I only met her on the day of his funeral. Because of COVID we could not meet. She had gone to see a spiritual adviser and Jack came through. He takes full responsibility for his death. I do not know if anyone believes in that, but you grab on to those little stories. I do not want to get emotional about this because you guys are here for a professional reason and I never wanted to be that person who tells stories.

ACTING CHAIR: It is all about stories.

Mr Martoo: I understand that.

ACTING CHAIR: Please do not hesitate if you want to.

Mr Martoo: Two weeks ago I was lucky enough to get five minutes with the Premier and Yvette D'Ath, the health minister, at the opening of the hospital. Just quickly telling them my story and seeing the connection that made with them and Minister D'Ath—I could see the tears and I see the tears in the eyes of everyone here today. Thank you, Amanda, for sharing your story. This is the reality. We just need to make that connection. We need to make sure that our young men and women—anyone—feels you are not going to be ridiculed for talking about this. We do not know whether that would have saved Jack. We will never know. But if we can just really knuckle down and get to that starting point where we can talk to each other and show emotion, I think that is a really big step in the right direction. As Michael said, talking to the community and have community-based programs is where it is at.

ACTING CHAIR: If we do not have any other further questions, members, we might leave it at that. Thank you so much for your testimony today. What you have provided to us today will change, I am sure, the face of the report we eventually present. Thank you very much, Michael, for your

contribution. There being no further questions that concludes our hearing for today. Thank you not just to yourselves but to everyone who participated. There were no questions taken on notice. Thanks to Hansard. I declare the hearing closed.

The committee adjourned at 1.56 pm.