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MENTAL HEALTH SELECT COMMITTEE

Members present:
Mr JP Kelly MP—Chair
Ms AB King MP
Mrs MF McMahon MP
Mr R Molhoek MP
Dr CAC Rowan MP

Staff present:
Dr A Beem—Acting Committee Secretary
Ms B Pye—Committee Support Officer

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

TRANSCRIPT OF PROCEEDINGS

FRIDAY, 18 MARCH 2022

Southport

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The committee met at 1.02 pm.

CHAIR: Good afternoon. I declare this public hearing of the Mental Health Select Committee open. I acknowledge the traditional owners of the land on which we are meeting today and pay my respects to elders past, present and emerging I would also like to acknowledge people with lived experience of mental health, alcohol or other drugs or suicidality. I would like to introduce the members of the committee. I am Joe Kelly, the member for Greenslopes and the chair of the committee. Mr Rob Molhoek is the member for Southport; it is nice to be in your electorate, Rob.

Mr MOLHOEK: Welcome to Southport.

CHAIR: Rob is the deputy chair. Dr Christian Rowan is the member for Moggill; Ms Ali King is the member for Pumicestone; and Mrs Melissa McMahon is the member for Macalister. We are not joined today by Ms Amanda Camm, the member for Whitsunday, or Mr Barry O'Rourke, the member for Rockhampton.

The purpose of today's public hearing 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 orders and rules. This public hearing is being recorded and a transcript will be made available on the parliament's website. You may be photographed today and images may also appear on the parliament's website or social media pages. I ask you all to turn your mobile phones off or to silent if you have not done that already. I advise people that if today's hearings raise any issues for you, please seek support. The secretariat can provide you with details of a range of organisations that can assist. This information is also available on our committee webpage.

BARRETT, Mr Michael, Chief Executive Officer, Mirikai Transformations Gold Coast

CRISP, Ms Harriet, State Manager, AOD Queensland, Salvation Army

PIMLOTT, Mr Aaron, State Manager, Homelessness Queensland, Salvation Army

CHAIR: Welcome. I invite you to make a brief opening statement.

Ms Crisp: Jingeri jimbelung, so 'hello friends' in the Yugambeh language. I would like to also acknowledge the traditional custodians, the Yugambeh people, whose land and waters on which we live, work and play and I pay my respects to their elders past, present and future. I acknowledge their continuing relationship to this land, their resilience and the ongoing living cultures of Aboriginal and Torres Strait Islander peoples across Australia.

Just as a brief introduction to our AOD services across Queensland, we have four: Mount Isa, Brisbane, Townsville and Gold Coast. There is a range of treatment options. We have detoxes in three of them. All four of them have residential rehabilitation centres. We also have a couple with community options.

The Salvation Army is embedded in communities across Australia, working wherever there is hardship or injustice. Our services include homelessness, family violence, alcohol and other drugs, youth services, chaplaincy, emergency relief and financial counselling. We also provide community connection and spiritual support through our cause in every state and territory. We have found that mental ill health is a factor in every service and every support that we provide. Mental health concerns are both the driver and the consequence of disadvantage. The Salvation Army appreciates the attention being paid by all governments of all levels to the issue of mental health and wellbeing in Australia. We acknowledge that numerous inquiries have been conducted to investigate the issues of mental health, suicide prevention and the services that address them.

Our submission focused upon the co-occurrence of mental ill health with substance use disorder. We believe that the co-occurrence of these issues in community members requires coordination and, as much as possible, co-location of services. It is critical that the differences of these skill sets and the needs of community members are respected. Although mental health is an

issue on a national scale, it is something that all governments, communities and individuals can work—and should work—to address through the alleviation of hardship through wraparound support including: more adequate youth services, supportive accommodation options and available and funded AOD services.

Our housing and homelessness services have significant exposure to the complex interrelationship of mental ill health and housing insecurity and how the lack of appropriate affordable housing compounds issues of mental health. That is why the Salvation Army is working to embed mental health supports into our homelessness services. Open dialogue among the client, mental health professional and support workers would inform case plans and optimise client outcomes. Thank you again for your time.

Mr Barrett: I am privileged to be here. I have been in this space for 22 years. I started the Transformations program on the Gold Coast in 1999. We are currently in four states of Australia. Recently we opened a centre in Cowra, New South Wales. We are in Melbourne, Victoria; in Hobart; and we have two in Queensland—one in Hervey Bay and one here on the Gold Coast.

We run a therapeutic community dealing with dual diagnosis case management. Everything you could possibly think of comes through our doors. We also recently started more of a private facility called Salt Recovery House out at Springbrook. We are seeing more and more mental health issues coming through there. Often we deal with the lower socio-economic cohort of the Gold Coast. I can say that the higher end of socio-economic has the same issues, especially since COVID.

It is a privilege to be here. First of all, I apologise for being late. Someone took my car. I had to Uber it here. Whatever we can do to contribute, we will do. I have done this on the smell of an oily rag. We do not really have much government funding at all. We mainly have corporate funding within the community. We have been able to be self-sustainable for the 22 years and have seen many people come through. Whatever I can contribute today, I am more than happy to do so.

Mr MOLHOEK: Chair, I should disclose an interest: I have made donations to Transformations in the past and more recently. This is disclosed on my register of public interests.

CHAIR: Sure. I appreciate that. Can I start with the Salvation Army. Can you step us through the sorts of services you provide across what ages? Are you only dealing with adults or do you have youth services?

Ms Crisp: Just for AOD?

CHAIR: Yes.

Ms Crisp: We are predominantly adult in Queensland, but we also have two youth services in Townsville. One is an outreach, out-client psychosocial model and the other one is a residential eight-bed unit.

CHAIR: Where does the funding for your services come from? Are the people who use your services paying?

Ms Crisp: It is a mix. We have Commonwealth funding and state funding, also through the PHN and also through NIAA out at Mount Isa.

CHAIR: Michael, you said that a lot of your funding comes through the corporate sector, so you are obviously a pretty good fundraiser?

Mr Barrett: Yes. I rub shoulders with certain people who have an interest in what we do. We have done a lot of fundraising over the years. We are now moving to a point where we will venture into the market of more of the government support as well, but we will always have a component where we are self-funded as well. That is the other reason I started Salt Recovery House as a social enterprise—to be able to support the work that we do for Transformations as well.

CHAIR: The Salvation Army has talked about the need for the co-location of services. Is that currently not the case? Are alcohol and mental health services quite separated? Is that from a Queensland Health perspective or is that across the board?

Ms Crisp: They are separate. We have strong linkages into other services and refer to them, and they refer to us. For example, we received some additional funding over the past year that we were able to use for a mental health nurse to come in and help assess our clients. That helped us greatly in terms of getting them through into mental health care plans—assessing the risk to themselves and to others and looking at better treatment planning for them. That would be a co-location model example that worked well for us.

CHAIR: The people who come to you for assistance obviously get that assistance while they are within the confines of your organisations, whether that is residential programs or non-residential programs, day programs et cetera. Is there a need in our community to have some sort of ongoing case management that follows people at high risk wherever they go, whether they are in your service or in a government-run service?

Ms Crisp: Definitely. We definitely see the need for post care. We are funded a small amount for some of that, but in our community setting, when we can offer a day program, residents can stay in their house, they can keep their children, their job—whatever. We can still help case manage them. That has worked well as well, but there is only limited funding for that. We are funded for residential services predominantly.

Mr Barrett: My perspective is that access to mental health services is so hard at the moment. It is so limited. Whether it is private, public—anything. Psychologists and psychiatrists are run off their feet. You cannot get a psychiatrist to see anyone for up to 12 or 18 months. In the past 24 months it has gone crazy. It is just so hard to access services, particularly for mental health.

CHAIR: In a service like yours, which is sort of primarily focused on addiction issues—

Mr Barrett: Addictions has changed. It really has evolved, particularly over the past 10 years, where comorbidity becomes our main focus. In terms of the dual diagnosis of mental illness and addictions, which came first? Are they self-medicating their mental illness with their addiction or did the mental illness come as a result of their addiction? Either way, we are dealing with both a lot more than we were before.

Mr MOLHOEK: I was going to suggest we ask Michael to share a bit of his lived experience and the background to him getting involved in Transformations. I am also keen to hear from Aaron or Harriet around some of the challenges you have with Fairhaven being located where it is. For the benefit of the committee, Fairhaven was originally built where the hospital is and then because the hospital needed all of that land they were built a shiny new facility out the back of nowhere which has created a whole series of other issues in terms of management. Perhaps you could respond to that, and then if Michael is happy to share a bit of his own journey I think that would be helpful.

Ms Crisp: At the moment the Gold Coast service has two sites. Our admission and intake is down in Southport, and we also have a dayhab there, which is a community program during the day. Mount Tamborine, specifically Eagle Heights, is where the 56-bed resi and 11-bed detox is. That limits us in terms of who we can take. We are up a mountain. We are far away from ambulances and the hospital. In terms of reintegration, we do not want to pluck someone out of their community and just throw them back in. We want them to be able to reintegrate into their community because the community connections are so important—those social and familial connections. They need to be able to connect to those mental health services and the whole gamut of holistic wellbeing, so they need to leave the service with those connections intact. As we were talking before about the close treatment time, it is so important that they stay connected to those support networks we have built with them. That cannot happen necessarily when you are up a mountain and then suddenly you are back in Southport. They then think, 'Who am I seeing?'

Just to add to what Michael was saying about the psychologists, we have seen that massively as well. COVID has had a great impact on psychologists' time as well. They are very limited, and getting a bulk-billing psychologist and/or psychiatrist is really hard for our participants.

CHAIR: It sounds bizarre where you are located, to be honest. I think a lot of average people would think, 'A mountain retreat is a nice place to go and undergo a drug and rehabilitation program,' but you need to rehabilitate people in their own community, in the environment they exist in.

Ms Crisp: Absolutely.

Mr MOLHOEK: It is actually an old model. When Fairhaven was originally built, this was all bush out here and it was here because they could not get into Surfers.

Mr Barrett: That is a really good point. We have always believed in homes within the community and to try to keep the homes smaller so it is less of an institution model and more of an integrated model, with the homes being separate from the place where the group therapy, courses and everything gets done. That has been a challenge with council zoning at times. We have had some challenges there. I remember when Fairhaven was trying to move up to Miami, to an old hotel. It was impact assessable and all the neighbours said, 'Oh, no. It's drugs,' so it has been a bit of a challenge to remain within the community and not get pushed to the outer limits. There is still that stigma around that.

I will give a bit about my story. I was a meth addict at the age of 22. I grew up in a really good family. For all intents and purposes, there is no reason we become an addict, but I was introduced to amphetamines from the age of 22 to the age of 27. At 22 I was paying off my own house, I was a tradesman pastry chef working at the Conrad Treasury Casino in Brisbane and I was engaged to my girlfriend of two years. I tried amphetamines and I remember thinking after that first taste of amphetamines, 'I'd better be careful with this. I could get addicted.' Sure enough, during the next five years I lost my house, I lost everything and I ended up on the streets of Fortitude Valley and just absolutely a shell of a person, helpless and hopeless.

My family cared enough to do an addict intervention on me, which was such a powerful thing, and I am a big advocate for that now. I carry out addict interventions and alcoholic interventions for families whose loved ones are addicted persons. They put me into Currumbin clinic. I did a detox at Currumbin clinic and then went over to Mirikai, which is Lives Lived Well now but was called Mirikai. I did their program and finished after nine months. I saw such power in the model of the therapeutic community and was really sold on it. It helped me to change my perspective and my thinking so much. There is the power of peer-to-peer based recovery, where no-one really knows what an addict goes through, how they think or their behaviour like another addict. I fell in love with it. I started what we would probably see as supported accommodation to begin with. I was meeting up with Mary Alcorn, who took Mirikai to great heights, and she was mentoring me on how to move it into the next level of becoming drug and alcohol rehabilitation and everything.

Over that first 10 years we evolved into a full program that has seen so many people come through and has changed their lives and helped them to become successful members of society. After that 10 years I tried to think how I could help more people, so we started to partner with other community organisations and churches around Australia to help them get real and lasting results with addicts with this therapeutic community model.

Ms KING: We were at a different therapeutic community facility this morning and they said that there were not enough detox beds in Brisbane. Was it 10 beds?

CHAIR: Twenty.

Ms KING: I am hearing that you have some detox beds. What is your take on the availability of detox beds for this region? How many are there and where are they located?

Mr Barrett: There are not enough.

Ms Crisp: We have 11 up at Mount Tamborine. We also have our Moonyah service in Brisbane, which has 12, and then we have Townsville, which has 10. We were not able to sustain the Mount Isa one because of a lack of resources. The workforce out there is pretty hard to recruit and retain. That is what we offer. Then there are the hospital based ones.

Mr Barrett: There is HADS at Royal Brisbane, which is probably the one you are thinking of. That is the main one for Queensland. There is one down at Lismore as well. There really is nowhere near enough detox beds. We cannot take people into the therapeutic community until they are detoxed, for various acute reasons with their health. There is a huge need for detox beds.

Ms KING: Michael, what is the pathway when people come to you? Do they present to you and then you try to broker them a detox bed effectively? Is that how it tends to work?

Mr Barrett: That is what we do. We work with Turning Point down at Southport. We work with HADS. It is ultimately why I am doing a private one now, where people are paying $1,500 a day to detox, and sometimes we will do some work with families to try to get them detoxed up at Salt or in a private Currumbin clinic or another private facility.

CHAIR: So the Currumbin clinic is a private facility?

Mr Barrett: They are private, yes.

CHAIR: Is it mental health and AOD?

Mr Barrett: Both. There are a few other private facilities. Hader Clinic is another one. There is Banyans up in Brisbane but they do not do detox, and there is the Sanctuary down in Byron Bay. They are more rehabilitation and mental health, but there is a big shortage of detox beds.

Mr MOLHOEK: I understand that 10 or 20 years ago, when a lot of these detox places were set up, people could go in for a week or two because the complexity of the drugs was different. Now with methamphetamines they actually need to spend longer in detox. Would it be correct to say that the problem is not that there has not been more beds but that people need to be there longer? Would that be accurate?

Mr Barrett: Alcohol, benzodiazepines, suboxone—a lot of the pharmaceuticals that were to get people off heroin and opioids end up being a longer detox, like methadone, naltrexone and suboxone, and more things can go wrong on the detox. With alcohol and benzos, they can have seizures and die, basically. The acute phase with methamphetamine is very acute psychosis. That is the big one that you are trying to manage—and that depends on whether they had a susceptibility to that before, but they have drug induced psychosis as well—where we need to lean into the acute mental health care team at uni hospital as well.

Ms Crisp: To add to that, we still do seven to 14 days. On average it is about seven days detox. Meth definitely is a longer period, but generally people are still coming in for that two weeks and then there are other effects that are managed ongoing from that. I do not think it is that we are keeping them longer and that is why the beds are tied up; I think we actually need more beds.

Mr Barrett: We just have more people who need help.

Ms Crisp: Our primary is alcohol as well, generally. It switches between alcohol and meth but it is generally alcohol.

Dr ROWAN: Thanks to both organisations for your submissions and particularly to you, Michael. With your lived experience, you are an absolute credit to yourself with everything else you have done. The Salvation Army does that work, but after hearing your personal lived experience and what you have created as well, congratulations for that work.

I want to come back to the detoxification beds, because that is the gateway obviously to rehabilitation. There are detoxification beds in not-for-profit and non-government organisations out there, but there are also those public beds that are needed because of the complexity and the acuity. If you have someone who has polysubstance abuse—the amphetamines and they have the psychosis—there is probably a level of detoxification that is required in a hospital based setting just because of the resourcing with the specialist medical staff, the nursing et cetera. In the Gold Coast region, I think the member for Southport in other discussions today said there are about 700,000 people here. Do you have any specific advice around those public detoxification beds? What could the government do to further partner with not-for-profit or non-government organisations with respect to detoxification that you do in your own services?

Ms Crisp: That is a good question. I guess it depends where you are as well. It just makes me think of Mount Isa, where people are having to fly to Townsville or Brisbane to detox, so we need more beds in hospital as well.

Mr Barrett: One comment I would make is that we need more communication and more of a consortium between the acute mental health phase of the hospital and the detox. They are not really mutually exclusive even though they are. This has been the big thing: is it medical, is it clinical, is it behavioural, is it psychological or is it more of the meds on the psychiatry side? If we were able to do, for want of a better word, a dual diagnosis detox clinic, that would be phenomenal.

Mrs McMAHON: I am interested in what your workforce numbers look like for both of your organisations in terms of a breakdown by their specialisations, their skill sets, whether you employ them or whether you outsource or bring in expert specialist clinicians. Then within your workforce, how many of them have lived experience or you consider to be a peer workforce?

Ms Crisp: We have a range of roles. In terms of the numbers, we would have to take that on notice. We have our management team and an admin team, we have caseworkers who do the day program with assistants and we have support workers who are around the clock whom we could not live without. They do a fantastic job; all of our staff do. Then in the detoxes we have a nurse team leader, a nurse manager plus nurses, mostly RNs—they are mostly registered nurses—as well as support workers. Then we have other caseworkers for our assessment team, so we have quite a range. Then we can meet with GPs. GPs are hard to find for our detoxes, so when we find one we really try and hold on to them, especially being specialised in AOD, so we do have trouble sometimes with it in various regions.

Mrs McMAHON: With those caseworkers and those supporters, what sorts of qualifications are we looking at? Do your RNs come with any mental health specific training?

Ms Crisp: For the RNs generally we require AOD experience. That is really key in the detox. A lot will have mental health experience as well. The example I gave before was of a nurse who could do mental health assessments where she has also had experience in detox, so that is a great match for us. Support workers will have varying experience and qualifications. The caseworkers must have a certificate IV or diploma level AOD. In terms of the peer workforce, that is something that we are

definitely having a conversation about and I think lots of people in the sector are at the moment. We do have a peer workforce in our Tasmania AOD services. At the moment we do not have a formal structured peer workforce in Queensland. We have many people who have lived experience.

Mrs McMAHON: I just noticed in your submission a recommendation to increase the capacity and the number of services. The mental health workforce, as we know, is stretched and there is not enough. In terms of the role that organisations like yours play in helping as we grow those workforce placements, do you take students on placements and those types of things to help us grow the workforce?

Ms Crisp: Mostly we are approached for social work students. In my two years here we have not been approached by a psychology student, but we probably would not have the program necessary for them to have a placement with us.

Mrs McMAHON: But certainly in terms of when we grow our mental health workforce, or, as you have talked about, those who specialise in AOD—

Mr Barrett: Particularly with case managers and caseworkers and support workers. The gold standard is a diploma in AOD and a diploma in mental health, obviously, but the minimal requirement is a certificate IV in the industry. Yes, we would welcome placements to get hands-on experience, for sure.

Ms KING: I have some workforce issues as well. I notice in your submission, Harriet, you talked about the need for housing in your remote and regional locations to ensure you can attract a suitable workforce. You said Mount Isa struggled in part around workforce.

Ms Crisp: Mount Isa and Townsville a bit as well.

Mr Pimlott: Yes, especially in those more regional and remote areas it is very challenging to maintain a workforce. Mount Isa is a great example. We have a homelessness service there that is active, but there is a bit of a subculture of the circuit of staff who go around from organisation to organisation. We have gone through the last two years trying to recruit. We do have a full team currently in our homelessness service, but the lack of housing is a challenge everywhere, especially in Mount Isa. We provide the support side. We work with community housing providers that provide housing with the state government. We are funded partially by the state government just under 50 per cent across the state; the rest is funded by the Salvation Army.

Ms KING: This is housing services for your participants or for your workers?

Mr Pimlott: For our participants, yes.

Ms KING: I am particularly interested in how it is that we encourage people to make a life in a regional area when they perhaps are not from that area. Over and over, every organisation we have come before in regional areas has talked about the importance of growing your own workforce and has said that if you can train and recruit from your local areas then people stay there. We also know that there is a need to bring people in. It sounded like you were advocating for a key worker housing model, where housing would be provided for the workforce. Was I incorrect? Let's have a look.

Ms Crisp: I do not know that we have gone to that much detail in terms of our thinking about it, but we can take that on notice and provide a more considered response.

Ms KING: I see. Yes, I got the wrong end of the stick here. You have made recommendations about improving housing affordability and regional and remote workforce, and I took those to be a crossover—that you were after housing for your workforce.

Ms Crisp: There is a little crossover.

Ms KING: I noted, Michael, that Mirikai Transformations is faith informed; is that right?

Mr Barrett: Yes. The Salvation Army obviously was birthed as a Christian organisation similar to us. Evidence based best practice shows us that it is biological, psychological, social and spiritual. Those are the four elements, and if we do not work on all those four elements—and AA and NA through the community have proven that that spiritual component has been a very important part of it. A big support network is the 12-step meetings after people leave because they are everywhere. Yes, ours is built on that Christian foundation. We do not in any way discriminate. We do not in any way proselytise, but we provide that as an underlying foundation of our belief systems of helping people to recover.

Ms KING: Do you receive feedback in either of your organisations from participants who do not find the spiritual model compatible with the way they see the world?

Mr Barrett: Absolutely. I think that is why there are different models. We all refer people to different models that are more suitable to them. We network with all different organisations, so we will try and get them the help they need. This works for them or that works for them.

Ms Crisp: We are a faith based organisation, obviously, and we definitely have those opportunities to explore spirituality. We have very strong links to core with opportunities, but none of it is mandated. It has to be optional for us within our model. There are people who have trauma histories in some of those settings, and that is not what we want to force upon them. We definitely have the links and the access, but it is not forced or mandatory.

Ms KING: It was feedback at one or more of our hearings about people who had trauma from those settings finding settings of faith difficult that led me to ask the question.

Mr Barrett: It has become a lot more apparent to us since the royal commission as well. Now there is a lot more sensitivity to it.

CHAIR: Harriet, you have those detox beds up at Mountain Tamborine. Is it always the case that people who go through a detox have the capacity to be linked to some sort of a rehabilitation and ongoing care service, or are there times when we just detox people, out the door they go and we hope for the best?

Ms Crisp: We are very individual. We have an individual approach. It depends what that person comes with and what we assess them with—what their needs are. For someone who is connected to their community and has another pathway, we will support that as well. We might have someone come to detox, stay an hour. They might come to detox and go home. They might come to detox and go to Transformations or the myriad other services there are. It depends on that person, and that is okay.

CHAIR: I just want to ask a question about the capacity to reach out to people around the person who is seeking help. I had the opportunity to participate as a nurse in rapid detox in an intensive care setting many years ago, and it struck me through reading patient charts that we probably need to be looking at their whole social sector to really try and help that person move on. What is the capacity of your organisations to reach beyond the individual who is immediately seeking help and look at the family, at least, if not more broadly?

Ms Crisp: We have a family group down here on the Gold Coast. It depends what the funding is, what the funding requirement says and what we can stretch. We use our support funding from Salvation Army as well to top it up. We also might have some value-add, so we might be able to add some of those other services. I think, like many services, we reach beyond what we are funded to do.

Mr Barrett: It varies so much when people come in, whether they have burned all their socials or not. We are proactively trying to reconnect them, and that happens through our case managers. We do an individual treatment plan with them where they are goal setting in those four different areas: biological, psychological, social and spiritual. They are looking at ways that they individually can set just little goals, working towards having good social networks and reconnecting with their social networks, and we encourage that.

Dr ROWAN: I want to come back to the dual diagnosis piece. Through this inquiry we have heard there has been increasing complexity and acuity in relation to dual diagnosis with respect to both comorbid mental health conditions and alcohol and/or drug disorders. Just to get a sense of the patients that you have, the particular demographics or trends, the length of stay that people are having to be in the service and what that means for sustainability of the organisations and what you have to provide, I guess I am, without leading, just asking about the complexity you are seeing. With dual diagnosis, does that mean that people are in treatment for longer and have more issues to be sorted, more interventions, and therefore there is a cost implication for organisations of that? If that is occurring, is that in particular demographics? Is it younger people? Is it those in that middle stage of life, older people? Is it across the board?

Mr Barrett: I would say it is across the board. Age is not really a factor. The acuteness of mental health and the link to trauma is massive. Unless we have the time and the resources to deal with the underlying trauma, yes, they will go back out there and fall back into the same hole.

Dr ROWAN: Is that childhood neglect? Is it childhood abuse? What sort of trauma?

Mr Barrett: That is another big question. We have CPTSD, which is complex post-traumatic stress disorder; then we have PTSD, post-traumatic stress disorder. The mental illnesses that stem out of that are a whole lot of anxiety disorders. We are seeing an increase in borderline personality disorder, which is something that has been rediagnosed and looked at over and over again. It used to be called multiple personality disorder, then it was disassociate identity disorder and now it is

borderline personality disorder, which just has such a broad spectrum, but it is all out of that trauma base. It is where the brain fragments off into another place and creates another personality, basically, to save the brain. It happens in the intensity of any type of trauma. It could be physical trauma.

For example, another lived experience for me is that my wife had postnatal psychosis first of all after a miscarriage, so I just could not work it out. She had a full psychotic breakdown and ended up in P1 in the Southport hospital. It was traumatic for me. Subsequently after all of our three daughters were born, she has then had relapses each year. I thought it was just about the hormonal and the postnatal stuff, but actually the trauma was from her as a baby because she had a club foot. When she was born, in those days they did not believe that babies felt pain and they manipulated the foot without medication and the trauma of that caused her brain to split off into a place of psychosis, even back then.

However, there are so many different things. We are dealing with veterans too. I just put in a tender—I think the Salvation Army put in a tender as well—with the Department of Veterans' Affairs so that we can get some funding for more veterans. Again, it is not just about the war; it is from childhood. Yes, we often hear about sexual abuse but there is physical abuse. There are so many different traumatic events that can then fragment off the brain. It is the brain's way of protecting itself.

Ms Crisp: One thing that we did notice during the pandemic was the increase in middle aged women with alcohol issues, so that was a trend that we really noticed throughout last year. That would be one of the ones from the pandemic as such.

Mr Barrett: Yes, then there is alcohol. Mainstream media said that alcohol consumption had increased 70 per cent, so you have all of these housewives who are getting into the plonk in the middle of the day and then getting depressed and suffering from anxiety and everything. It is men as well. Alcohol is a depressant, so it might give them temporary relief but then not.

CHAIR: Aaron, in terms of people who are experiencing homelessness, what is the availability of mental health services for people in that situation on the Gold Coast or in the areas you have responsibility for?

Mr Pimlott: It is very few and far between. We have a similar model of staff. We have case managers that provide support and look at addressing providing support around the goals of that individual as part of an individual, person centred, trauma informed approach. We will take a housing first approach with support. In terms of access to mental health, our case managers are basically doing the run-around trying to find adequate supports for the people on their case load. For our homelessness services, Queensland Health is really the only option that is available for us at the moment. It can take time for that referral to happen or the referral to connect and for someone to either attend site or attend the person's home. It is just a massive gap with multiple challenges that we are working with. If we cannot address the mental health side, all the other work that our case managers attempt to do will be very short lived.

CHAIR: Do you notice in either of your services that women becoming pregnant is a trigger point for seeking assistance to move away from problematic alcohol or drug consumption?

Mr Barrett: Not a real trend I would say, and there are not many facilities for pregnant women or women with kids. That is another big shortage—massive need.

CHAIR: Do you have a lot of families—women with kids or husbands and wives with kids?

Mr Barrett: Yes, single mothers. Unfortunately we have to tell them—because we do not have the support for that or the funding—'We can only take you. You're going to have to work out something with your children.'

CHAIR: Right.

Ms KING: Is that a barrier where people then disengage routinely?

Mr Barrett: Yes, and then they are out there on their own.

Mrs McMAHON: I represent a portion of Logan in my electorate and we have Logan House which, I believe, is a model of residential care that includes the whole of family but has limitations obviously on capacity. Do you see a growing need for a whole-of-family approach to dealing with a lot of the issues that your organisations are facing?

Mr Barrett: I think we need to have it as a resource, yes, and I think it could be a stepped approach where you are dealing with perhaps individuals. I am always about reconciliation if we can do it—husbands and wives, fathers with children, mothers with children—and sometimes it needs to be a stepped approach, so then if we had that facility where they could live in care and they could progress into being independent that would be fantastic.

Ms Crisp: We do have that out at Mount Isa, so we take singles, couples or families and so children come to that service.

Mrs McMAHON: What is the capacity there in terms of how many family units you can have at any given time?

Ms Crisp: It depends how the rooms get configured, because you can open doors between rooms and things like that. It depends what the mix would be and how many children. We are funded for 28 adult beds, so the children are not included in that number.

CHAIR: It sounds to me like a lot of the people you work with have probably hit rock bottom and are pretty advanced in their pathology of their issue. Do you think there is more that your organisations could do in those earlier phases, when people might be much earlier in the phase of having a challenge with alcohol or drugs?

Mr Barrett: Before I started I wanted to save the world, so I started all of these things and then I did not have the funding. Most of my priority and focus now is on Transformations across Australia, from the governance level and accreditation but also from self-recovery. I started Drug Awareness Australia as a model to be able to do intervention, support like a peer support model and education in schools. If we could do that, I would feel like we were doing every step of the way. Yes, I would rather not be the ambulance at the bottom of the cliff all of the time.

CHAIR: Right.

Ms Crisp: We are keen to expand our community options. Resi rehab is the most intense and end-of-the-road kind of intervention, so if we could get people coming to Smart Recovery or the dayhab while they keep all their connections to community that would be fantastic. That is what we try to do with the funding we receive.

Dr ROWAN: In the opening statements from the Salvation Army you said that mental health disorders and alcohol and other drug conditions are both a driver and a consequence of disadvantage, and I think Michael said before that when he started out he wanted to save the world. There is a huge amount of complexity here and a huge amount of work that needs to be done across the board, but the thing I am really interested in from a state government perspective is: if there are just three definitive recommendations that you could give to us that we could take away and say, 'This is what we could do or the change we could implement that would help service providers in the community'—knowing that government cannot do everything—what would they be? If there were three particularly from a state perspective, I would be really interested if both organisations could say, 'We'd really like you to do this and this would make a difference to those people on the ground who need access and good, evidence based care.'

Ms Crisp: Gosh! Waving a magic wand, finding a way to increase the amount of accessible mental health care that is bulk-billed, so I guess that is doable. There are psychologists out there who do not bulk-bill them, so that is a barrier for us, if we even find a psychologist to begin with. Three? Goodness! Probably making sure with mental health and those qualifications that AOD is definitely a part of that and equipping that workforce as well in terms of AOD and addiction treatment and what that looks like where we interact. I guess the same could be vice versa for AOD. We generally have to deal with it, so we do train in that area because we have to deal with the mental health issues. I might come back for a third one and throw to you.

Mr Barrett: I think there is a big highlight on detox beds. I would say that would be No. 1, because if they want to enter detox it is very hard to get them in. That is the first point. If we are talking about the ambulance to the hospital, they are the paramedics. They are the ones getting them right there on the edge of death to get them into the rehab services. I agree about more centres that are equipped with psychologists, psychiatrists and all of the top end of the scale of mental health and then also more caseworkers. NDIS has been a bit of a help, but it is just such a broad thing and it is hard and then you have these people who are not qualified who come along to support the disabilities of mental health. They typically get paid a lot of money to be their friend. That is great, but we are not getting them anywhere. So we need more qualified case managers that are funded to be able to step into those spaces, integrated into the community as well as in the residential.

CHAIR: That is very interesting. We have heard that before in other hearings.

Ms KING: Yes, and I have heard it in the other committee.

CHAIR: We were alerted today to problems that people with alcohol and other drug issues face in terms of their dealings with Centrelink and having acceptance of their condition by Centrelink for the purposes of not having to go through the rigours of trying to find a job. Is that something that you folks have run across?

Mr Barrett: Yes, it has sort of morphed and changed quite a lot. It used to be—I do not know what they did—that a Centrelink person would come out and they would be particularly assigned to the rehab and they would take everyone through and short-track the process and then that just stopped. They said, 'We don't have the funding for it or we can't do it,' so that would be a real help if we could do that again.

Ms KING: Was that in terms of helping them apply for Centrelink benefits to start with?

Mr Barrett: Yes, get them on to the Centrelink benefits or actually get them on to a medical certificate to say that they are incapacitated from working now and they are doing a program. They are on JobSeeker. There used to be a couple of other ones that were like a medical based sickness benefit, but that has changed again. We have to try and play cat and mouse to keep up with what is shifting and changing, and, yes, myGov is a little bit more helpful because you can go on a computer and work out if their Centrelink is all linked, but often these guys and girls who come to us have not done any of that. They are flat out brushing their teeth sometimes.

Ms Crisp: Just to add to that, we have lots of people come to us who might have mental health issues but they are not diagnosed, or if they are diagnosed they have not had treatment or medication for a long time, so that adds to the complexity of whether you have evidence for Centrelink as well.

Ms KING: Michael, in your earlier submissions you talked about addict interventions and you said your family provided you with an intervention. I wondered if you could just talk a bit more about that concept and what you have seen it involve in different people you have worked with.

Mr Barrett: Yes. It has predominantly been a big thing in the United States. My sister was working as an actress in the United States and she flew back. She learned about it, got trained in it and flew back and did the intervention on me.

Intervention, for want of better explanation, is like a surprise party for the addict or alcoholic where all their friends and relatives come around to confront them about their substance abuse, but it is very caring. It is probably the most loving ting that you could ever do for an addict. People think loving them is enabling them and giving them money. Manipulation and dishonesty go hand in hand with addiction and alcoholism. When an intervention is done properly—I have seen families try and do it without an interventionist and it can go terribly pear-shaped—there is a 95 per cent success rate of that person going into treatment. These are statistics from the United States. Even if they do not go straight into treatment, which is the ultimate goal, it is said that their using is not the same after the intervention. It is like they are using with a conscience, because they have heard the magnitude of the love of the family who has tried to rope them back in, slide under all their defences and talk to the person and not the addiction.

Denial is such a powerful part of addiction. I heard it once said that denial stands for 'don't even know I am lying'. It is about breaking through the denial. I have done a number of interventions. Recently I flew up to Gladstone as a family had asked me to go and do an intervention. I had three meetings with the family and then we planned the intervention. The addict was there and they were hopping mad. They felt betrayed and said, 'How come I didn't know about this?' After that, they broke down. They were in tears. They said, 'I don't want to do this anymore.' I brought them back on the plane, which was quite a mission, and they went into treatment.

Ms KING: That would obviously only work if you have a direct line into detox and then a place in a rehab program lined up and ready to go?

Mr Barrett: Correct. I can do it because I have the detox solved and then I know that Transformations has a bed available for them. Often interventionists in the US will work with rehabilitation programs and centres. Yes, it is the front line of rescuing them out. It confronts the theory that an addict needs to hit a rock bottom.

CHAIR: On that point, I would like to thank both organisations for coming and presenting today. The information you have given us will be extremely useful in preparing our report and our recommendations, which we hope will make some difference to the lives of people who are experiencing alcohol and other drug issues.

There were a couple of questions taken on notice. We need the response to those questions by Friday, 25 March. On behalf of the committee, I thank you very much for the work that you, your staff, your volunteers and your peer support workers do. It has been a very difficult couple of years with COVID, but we do greatly appreciate the work that you continue to do in your space. Thank you very much.

LEEBEEK, Ms Maria, Chief Executive Officer, Gold Coast Youth Service

SLAVIN, Mr Matt, Team Leader, Gold Coast Foyer, Gold Coast Youth Service

CHAIR: Welcome. I invite you to make a brief opening statement. Then we will go to the committee for questions.

Ms Leebeek: The youth service has been around for 30 years. We are a specialist not-for-profit service mainly focused on young people who are homeless and at risk of homelessness. We do support their families. We cover the Gold Coast local government region pretty much. There are some exceptions to that. I will go into that in a minute.

We do early intervention. We have a YASS program. Basically, we go into schools and work with families to try and keep young people in school. The whole focus is early intervention. We have a crisis support service, so young people can walk in; there is no-barrier access for young people experiencing homelessness or at risk of homelessness. We also do an outreach service on the street called Street CRED. We have, I think, 14 partners that we do that with. We meet young people on the street and see why they are there. We also do continuing care and life skill development. We have 12 units of accommodation as well as the 40-bed youth foyer, which Matt will talk about during the course of our presentation.

We also work with Youth and Family Support Services and cover quite a large region across the south-east for Next Step Plus. They are young people transitioning from care. The reason we went into that space is that 30 per cent of young people transitioning from care are homeless; 50 per cent are experiencing homelessness after five years. They were coming into our service, so we felt that we wanted to go into that space. That is quite new for us; we have just done that.

We are also an emergency and relief provider for the whole of the region. Currently we are also supporting people in the flood zone in northern New South Wales. We conduct the Chill Out Zone, which is a program in the safe night out precincts of Broadbeach and Surfers Paradise.

Last financial year we knew 1,468 distinct young people. An additional 200-odd we knew by name. That is 1700 in total. There are a lot more young people who come to us whose details we do not capture. Some 735 households were assisted and 4,000-odd people came through the Chill Out Zone. That is who we are and what we do. Our statement today will focus on those young people who are at risk of experiencing homelessness. Our statement relates to 1(a), (c), (e), (f) and (g) of the terms of the reference. We are not trying to cover everything in the terms of reference. We are very specific.

In terms of point (a), I had a quick look at the data for December to see how we compared to the national data. In Queensland, about 24 per cent of people who experienced homelessness or in homelessness services had a current mental health issue. Our statistics are about the same. However, when we asked young people when they came to our service whether they had a diagnosed mental health, 56.4 per cent—and I think that is about the population—had a diagnosed mental health. We do not do NDIS, but there were a small number—about three per cent—who were in receipt of an NDIS package. This means that they are homeless, not getting supported and coming to our service to seek support.

Our age group is 17 to 25. Most who come to us are couch surfing or in some sort of insecure housing. About a quarter of them are rough sleeping. Most are unemployed. Some have no income. Very few are undertaking education or employment. About one-fifth, or 20 per cent, are Aboriginal and Torres Strait Islander. They are coming to us because they are poor. They are in poverty and they need housing. We referred about eight per cent of the young people we worked with to some sort of psychological, psychiatric or mental health service.

We know that there are a whole range of reasons—biological, social and environmental—for poor mental health. For us, the experience of homelessness and trauma associated with it really does impact on mental health. We can see that and we know it. Their homelessness is long. For NESB data and young people transitioning from care, that is a five-year timeframe. We are talking 18 to 22. Their experiences of homelessness are long term.

We talked about trauma before. For us it is trauma. It is a case of the chicken and the egg: is it mental health first or homelessness first? What happens is that, in the end, young people have unmanaged mental health and homelessness, and this impacts on schooling, education, employment and training. You can see that through our data. We also see the high rates of substance misuse because this is how people are managing. How are you going to deal with that trauma? 'I am going to have a drink.' That is a form of self-medication.

I also want to put a gender lens on this, because there has been a lot of conversation about older women who are homeless. If we do not deal with the young women who are homeless, they are going to be the older women who are homeless, unfortunately. We really want to focus on them having the opportunity to complete their schooling to have a higher income. They are going to have children—the whole story. If we do not deal with young women and their children at the front end, it is no surprise that there will be a correlation to older homeless women. They are all subject to the vagaries of the rental market, which is highly problematic. This is the reason we pushed—and Matt will speak to this—for young women to be with their children in the youth foyer.

The Productivity Commission report reflects what is going on for us. I note that 1(c) is about opportunities to improve economic and other participation. I want to address some underpinning assumptions about that. The underpinning assumption is that you have a home; you have a regular phone number or a phone; you have a GP and you are accessing some sort of mainstream service. That is obviously not the case for the young people coming into our service. For us, the first thing is that you need housing. I do not care how we do it, but we need more housing. Without a stable home, you cannot pivot on anything else. Again, Matt will talk about why that happens at the foyer.

The other thing is that we get calls every week from the mental health ward saying, 'Can we discharge a young person into your service?' We are a homeless service. They are not discharging them into housing; they are discharging them into a homeless service. I am not really sure what they think we can do, but we do try and work with them. I do not think that is anything to do with the people who work on the wards; it is just a systems issue. There is nowhere to go.

The second part is their treatment plan. If you do not have a home, I am not sure how you are doing the rest of the treatment plan. I would love to have a GP at my service at least. Back when we did the Burdekin inquiry, adolescent health, GP services for young people and innovative youth services came out of that. I do not know where they have gone, but certainly that would be something to revisit. People need help to navigate the system, because coming to us is really concerning. Coordination of services is an issue when young people are rough sleeping and homeless—particularly between mental health and AOD.

I want to tell a story about a young woman. It is a true story. She is in her mid-20s. She comes from a very loving home. She has a good education history. There has been lots of trauma—the suicide of friends. She disengaged from school and turned to AOD to forget that history and she has experienced rough sleeping. Whilst on the streets she has been raped numerous times and, therefore, there is more trauma. So you have trauma on trauma. She then had a drug induced psychosis and went into hospital. Basically what happens from there is: she goes in and sobers up and they say, 'You're fine. You can go now.' Then when you go to AOD, they say, 'You have mental health.' That problem—which is historical and has been around for a long time—is still a problem that we are having now. This woman continues to present to mental health. She presented this week saying, 'I'm unwell' and was turned away.

My challenge is that with COVID we have talked about mental health. We say, 'People have been sitting at home and it has been a big challenge.' When I say, 'Here's a young woman,' and you are saying, 'She doesn't have mental health,' I am sorry, but which bit of that shows that she does not have mental health? I have gone all over the shop around this issue. You cannot keep saying 'that is alcohol' or 'that is mental health'.

CHAIR: Effectively what you are saying is that if somebody who has an alcohol and drug problem fronts up at a mental health service or ends up in an emergency department and gets referred they will be basically refused service because of that alcohol and drug problem?

Ms Leebeek: They let them in, do a quick check, but then they go out. In Southport we have quite a few people who are rough sleeping or homeless outside of my age group, but ostensibly the core of those people there all have a significant mental health issue.

CHAIR: If the person is asked to go to the alcohol and other drug service, they go there and then they say, 'Well, you have got a mental health problem. We cannot help you.'

Ms Leebeek: Yes. Our solution was to start the Gold Coast Zero project. There is a Brisbane Zero, an Adelaide Zero. What we are basically saying is that we need to be focusing on the people. We need to do wraparound support and we need to look at housing as the solution. We have also advocated for a Common Ground on the Gold Coast and have been for some time, because the reality is that for a lot of the people that we are talking about the capacity to sustain accommodation is incredibly hard too so we can get them into accommodation, into housing, like a Common Ground where there is a concierge at the bottom—and that is what the Foyer is. The Foyer is for a different kind of group but the Foyer is supportive housing as well.

When we are looking at young people who are not as acute as that but are presenting to us and they have a mental health issue, what we are saying is that we are going to put them into housing, we are going to support them around what their aspirations are and in the process we will support them around their mental health, and the same with others. You cannot do anything else otherwise they are just revolving in and out of the system.

CHAIR: I will come to the housing issue in a second, but I wanted to clarify that issue. It seems surprising to me. I am a nurse by profession. We would occasionally get a patient who would wind up in the wrong ward. They get misdiagnosed. I was last in the stroke unit. You often get people who come in with a stroke but they had something else. You would not think to send them back to the front door and say, 'Go and get to where you are supposed to be.' We take responsibility and move that person to the place where they get the service that they need. That is not happening.

Ms Leebeek: People are not necessarily always as compliant as the system might want. Going to a Zero is about saying, 'How can we come and wrap around better? How can we do that better? What is the follow-up support then and how can we do it?' The other thing I talk about is: can we have clinicians on the streets doing stuff with people out in the community? We make an appointment time and they do not show up. The whole concept of a rough sleeper going, 'Yes, I will just make that time', is a very difficult thing. We talk about assertive outreach in homelessness and I think assertive outreach is the way to go, where you are going to people and checking in and hopefully in time they will be wanting to do that engagement.

CHAIR: In relation to the issues around housing, what is the solution? Is it simply more social housing? Is it social housing with support services like Common Ground?

Ms Leebeek: Supportive housing.

CHAIR: It is not just more social housing; we need supportive social housing?

Ms Leebeek: We need more housing generally for everybody. Housing is an issue. Everyone has a housing issue at the moment. For a cohort of people who are chronically unwell and quite distressed, you need supportive housing. You need a Common Ground. I cannot say that enough times. It works. I know it works.

Dr ROWAN: Thank you both for attending today. I want to follow on from the member for Greenslopes. You were talking about trauma. We have asked other providers in different hearings that we have had whether we should have a whole-of-government trauma strategy, to have that sort of wraparound support that you are talking about with housing and accommodation being at the centre of it. With a lot of the issues, particularly for young people, trauma in all its forms underpins many of the issues that are having to be dealt with. It cuts across all those departments, whether it is housing, health, education, child safety or corrections. My question really is: should the government consider a whole-of-government trauma strategy to look at all of those aspects given that it cuts across all of these departments? There are lots of young people with trauma related issues who need coordination and collaboration to sort their issues out and be provided with the support they need.

Ms Leebeek: I think everybody should be trauma informed. We have talked about it forever. Trauma informed practice is everywhere. The question is: can you do it? Does a whole-of-government strategy do that? I have a YASS program. We go into schools. We work with families. We are person centred. We say to the young person, 'What do you need and how can we support you to stay in your family?', and then we work with that. Once there is disengagement, once you are disengaged from school, then where do you go? That causes stress in the family. Are you going to get a job? What else is going on for you? I would rather see that focus around early intervention.

During COVID it was one area where we had the most pressure in the organisation, with families coming up to us because kids were at home as well. I think there was lots of stress around COVID and young people being at home.

We have gone to philanthropic organisations. The Frizzell Foundation has assisted us to have another worker and we are working towards arguing to government that we need more workers like that. We are getting a number of referrals from a number of places. You are trying to keep young people at home, engaged, in pro-social activities and then moving on in their life. We have had about a 50 per cent success rate for kids who have a mental health case plan doing their case plans in that program. For a service like ours, we are not child protection or youth justice; we are not boxed in. We are a service that can wander over a number of agencies. We are the lead for the young person and we will then attempt to negotiate the system. For me that would be much more practically useful for young people and their families.

Dr ROWAN: How do we take what you are achieving through your service, the Gold Coast Youth Service, and extrapolate that across Queensland because we want the same thing to be happening for a child in Mount Isa or Cairns?

Ms Leebeek: Increase the program funding for the YASS program. Simple. I have two workers. I have had two workers for forever. I have to go and get philanthropic funding to put the argument forward to government that I need more money. We spent six years fighting for the Foyer but in the end we got that. Build more Foyers. I could do with another one. I think Victoria went from three funded out of the AFL to 12 or some ridiculous number because they recognise the value of it. Housing first; do the support.

Mrs McMAHON: You are one of the few organisations that we have spoken to that has really focused on the youth space. We have received a few submissions that have advised the committee about the issue of transitioning from child youth services at 18, straight into an adult system. We have had some recommendations that we look at youth mental health that goes all the way up to age 25. Could you, as providers in that space, comment on that perspective? Can you give any examples of the disconnect where as soon as they become an adult either services drop off or they disengage, so all of the work that had been done in the lead-up to turning 18 falls away as they lose their way in the adult system?

Mr Slavin: I have seen that a lot, that transition for young people and adolescents into adulthood. Obviously particularly in the context of care, they have a lot of support to do that stuff for them and then they leave care and, without places like Next Step Plus, they are left by themselves to do that piece of work and they are not doing it. It is a minefield to try to navigate so they fall back from services. That transition is very seldom done well. It takes comprehensive case work from the department and their case workers and whatever other services they have.

I think that is a fantastic suggestion, increasing that; it would be in line with some other pieces of work where they are extending that out to 25. I think it is quite critical. It does get lost. I have transitioned many a young person from state care into complexes. They have been fortunate enough to get a house, but having all this 24/7 support or having loving foster-carers and then all of a sudden their support networks are completely gone, they are isolated by themselves and they are left to deal with very complex situations completely by themselves. The Carmody report and things like that have helped along the way. I think that would be a very good extension and it is needed because it is just getting lost.

CHAIR: Are the young folks in your youth Foyer case managed? What is the sort of time frame that they spend in the youth Foyer?

Mr Slavin: Up to 24 months is what is prescribed. There is a bit of flexibility. The whole idea of the Foyer is that it is not case management per se. We use a coaching and mentoring, person-centred kind of approach. I think that has been very critical. There is 24/7 on-site support too, which has been a very useful component of our support so far. We are in our infancy. We are only six months old. We are doing what we can and are still doing a lot of that operational build-up stuff.

Having that on-site support has been critical and very helpful in achieving some great outcomes so far. We have 87 per cent enrolled in education or employment. The mums and bubs are doing exceptionally well. That was a bit of a nervous space, having that on-site support for the mums who are incredibly lonely and do not know how to navigate this stuff. Having someone there by their side is huge. We talk about social isolation particularly in the context of kids leaving care and not having those supports. It is massive. Having that has been incredibly useful, so much so that, particularly in the context of mums, we now have a mum working full-time. Her trajectory for independence is well and truly on the way. Another young mum came to us at 23 weeks pregnant and now has had her baby. She was able to finish year 12, she was able to arrange a few things, get her licence and now she is enrolled to do social work part-time next year. That would not have happened without on-site support. That would not have happened without stable accommodation.

CHAIR: That is great.

Mr MOLHOEK: I get so excited about the youth Foyer model. For the public record, I need to acknowledge Ruth Knight who first talked to me about that over 10 years ago. As a result, the first pilot was at Logan. It was a model that was designed, as I understand—and perhaps you could comment on the progress with the Southport one—to also provide a more cost-effective alternative to residential care for young people when they got to that age in the foster care system where they needed to live independently. Rather than putting them in a group home at $400,000 or $500,000 a year plus per child and them not wanting to be there, they are put into an environment where they can live independently and have support. I would be interested to hear your comments around that.

Mr Slavin: Currently we have about 28 per cent of young people from state care. It is not solely for that purpose, but 28 per cent currently are from state care.

Ms Leebeek: It is definitely more cost effective.

Mr MOLHOEK: And there are actually better outcomes.

Ms Leebeek: Yes. The equivalent probably would be an eight-bed crisis shelter.

Mr Slavin: Working in that space previously, the life skills do not often get developed so they are reliant on the support workers in state care. Here they are independent. They pay 28 per cent of their gross income, they pay for all their bills, their food and whatever else, and we do the coaching, supporting and budgeting. There is brokerage support to help with some of those things that come up, in particular the cost of getting assessments or those pieces of work that have not been done pertaining to their mental health. Having access to additional funds to help with that is critical to set them up for future success.

Ms Leebeek: Casting back—just doing a casting back, casting forward—when I started 30 years ago we had a whole lot of young people who were rough sleeping on the street: 'We are street families', blah, blah, blah. That was a whole part of homelessness. You look at the data now and the field have done a lot of work around not wanting to be at the crisis end; we want to be doing early intervention and we want to be doing all this other stuff. If you look at the data—it will be interesting to see the census data that comes out soon—you will find that rough sleeping/homelessness for young people is very small as a percentage now. Most of them are couch surfing or in some sort of insecure housing.

We have done good things. Investments have been in the right places. It takes time to show the reward, but the reward is there. That is why we are still arguing around, yes, can we do more early intervention, can we do more housing like the Foyer. It is those sorts of things for young people so that you are not having this older, more chronic homelessness. It is those sorts of things that you are trying to address. Alongside that comes all this chronic mental health as well. So, can we manage and support people to manage their mental health and have happy lives, hopeful lives. That is the idea.

CHAIR: On that point I would like to thank you both for coming along today. Maria and Matt, on behalf of the committee, I thank you for the work that you do and will continue to do. Thank you to all of your volunteers and your staff. It would have been a tough couple of years with COVID and we appreciate the work that you have done. The information that you have shared with us today has really helped the committee. It will certainly help to inform our report and our recommendations going forward. We genuinely, sincerely hope that we can get some action out of government that makes life better for people experiencing mental health issues, alcohol and other drug issues, homelessness, et cetera. So thank you for your time today.

Mr MOLHOEK: For *Hansard* I think it is also important to acknowledge Maria's work with the Gold Coast Homelessness Symposium and bringing together many other stakeholder groups over many years to work on this problem. Thank you for that work.

Ms Leebeek: Thank you.

LEWIS, Ms Susan, General Manager, Strategy, Innovation and Research, Accoras Gold Coast.

CHAIR: Would you like to make a brief opening statement?

Ms Lewis: Yes, I would, thank you. I would like to thank you all for this opportunity and I would like to acknowledge the people of the Yugambeh language region and pay my respects to their elders past, present and emerging.

I am here today on behalf of Accoras, an early intervention mental health organisation that operates across South-East Queensland. We believe in good mental health for all and that early intervention when problems first emerge prevents both immediate suffering and long-term social, economic and personal costs. Our experience has taught us that an holistic approach to mental health care is essential, accounting for all areas of a person's life, their family and their community. Effective mental health intervention starts with what we know good mental health requires. In short, good mental health requires that someone is living a good life. What does that actually mean?

At its foundation good mental health requires: feeling safe, secure housing, a stable income to provide for yourself and your family, and being free from harassment or threats due to your race, religion or sexuality. Safety includes freedom from childhood trauma, abuse, neglect, domestic and family violence and the impacts of caregiver substance use. It requires meaningful and supportive relationships with the people who matter to you; relationships where you feel looked after, that you matter and that you are loved. It requires a connection to your culture and where your people have come from, particularly for First Nations people and their connection to country. It requires the ability to look after your physical health: sleep, exercise, nutritious foods and equitable access to health care. It requires a meaningful way to spend your days. For most people that is school, work or caring for children or others. For other people it might be volunteering, advocacy or otherwise contributing to their community. An occupation gives you a routine, a sense of purpose and achievement and frequently an income. All of these matter for good mental health. Finally, good mental health requires feeling confident about yourself, your world and your future and that you have the ability to bring about good things in life.

If someone lacks the resources to live a reasonably good life, mental health services will struggle to make an impact. A therapeutic relationship of an hour a week or a fortnight where a person is supported to change their thinking, behaviour and emotional responses is important. Medication is important. However, where a person lacks safety, good relationships or a meaningful occupation, a clinic-centric approach to the treatment of mental illness can fail as it implicitly sets the expectation that with treatment the individual can facilitate a significant enough change in their circumstances to recover. But the world we live in is more complex than that and particularly so for children and young people whose brains are still developing and when so much of their life is in the control of others. Where children do not feel safe and supported, they lack the executive functioning to engage with and benefit from traditional therapy. That is why we say effective mental health care demands an holistic focus involving parents and carers, with focussed supports to succeed in education and employment, help to secure stable housing that responds to cultural and spiritual needs, and care that is integrated and coordinated with other healthcare and social supports. Where mental health care does not undertake an holistic assessment to develop a treatment approach that incorporates all goals and important domains for the client, it can and does fail. You do not need to take my word for it. Consumers have been saying this for a very long time. It is one of the reasons that lived experience in governance and our mental health workforce is so critical.

There are already services funded to support people across these life domains. I know there is a need for increased mental health funding in Queensland. However, we also need to attend to maximising the effectiveness of the funding we already have, and collaborative approaches and integrated support systems where government departments, NGOs and the private sector provide an integrated response to the people who need it most. Key drivers of community mental health in the control of government are education, housing, health care, child protection, disability services, transport, development and infrastructure planning, community services and early childhood education and care. The way they are delivered, their policy priorities and their funding levels impact all members of the community. All need to be accessible, equitable and effective, and coordinated to maximise community wellbeing.

I will close by saying that if we want the greatest economic impact for our mental health dollars then we need to invest both early in life and early in illness, particularly supporting families to give children the best start in life and the best opportunity to develop healthy brain architecture through supportive relationships, good nutrition and the ability to safely explore their world, develop and grow.

This is especially important for vulnerable and marginalised children and families. Mental health and social programs that target parents and help them understand and support optimal child development reap rewards throughout the lifespan. Thank you.

Ms KING: Thank you so much, Suzie. It has been very interesting to hear from providers, including yourself, about the challenges where systems do not work together or where they do not overlap, effectively. That was what I took from much of your initial remarks. I want to ask you some questions, if you do not mind, about your unique program. Our notes say that you are a free outreach support service for children and young people with early signs of mental health concerns. Can you please speak to us about what is involved? How do the people involved in delivering that care and support navigate what might traditionally have been different service domains of, say, child safety, health, mental health?

Ms Lewis: Probably the first important thing to say is that the way we approach our mental health services is primarily through outreach. The unique service is an exclusively outreach model. That means we are going into homes and schools to deliver the services. Our experience is if we want children and families to develop skills and benefit as much as possible from an intervention, it has to happen where the behaviour change needs to be and where expert structure and scaffolding needs to be. It is an early intervention program, but that does not mean we do not take a community and case management focus.

One of the things that we need to do in that intervention is to work really closely with schools, families and extended support systems. Something that is a little bit different about how we approach that is when we go into schools we are not just going in and talking about the one young person who has been referred to us. We are offering school communities the opportunity to take part in workshops. Entire classrooms benefit from different programs we can offer though groups and mental health illness prevention programs. We also offer to upskill education staff, teachers and support staff. We know that putting all of our energy into one child or one child and one parent is not actually going to reap the rewards or see the changes that we are really looking for. For sustainability, if we can take everyone with us on that journey and upskill everyone and improve everyone’s mental health literacy, we will have a much better outcome.

Ms KING: What might be the kind of prompt that leads to the delivery of that service in, say, a school setting? Is that because you are getting a call to say there are concerns about this young person and their family or are you engaging with schools to be there before those concerns even arise? How is it happening that you are delivering these services to kids?

Ms Lewis: Usually it would be where we are seeing a number of young people being referred from one particular school. As much as we would love to be in schools before that occurs, we are not resourced for that. It is where we have had the referrals and where we are particularly noticing patterns. If we have a number of adolescents referred with violence in their romantic relationships, we will be off to the school offering to deliver Love Bites as a domestic and family violence prevention program.

Ms KING: Could you tell us about that? I am sorry, Chair. I am sure there are other people waiting to ask questions, but this is very interesting: a domestic violence prevention program for young people about relationships.

Ms Lewis: For adolescents, yes. It is going into the schools and talking about respectful relationships, trying to change maybe established gender norms and talk about what a respectful relationship actually looks like. It is important for all young people. It is particularly important for young people who have grown up in households with domestic and family violence and might not have had an opportunity to see up close a respectful romantic relationship. It is called Love Bites.

Ms KING: Where do you deliver your programs? That is my final question and then I will let everybody else have a go.

Ms Lewis: We offer unique programs on the Gold Coast and South Brisbane, but Accoras delivers services across the south-east region and over the border in Northern New South Wales.

CHAIR: Is Accoras a non-profit organisation?

Ms Lewis: Yes, we are a for-purpose charitable organisation.

Dr ROWAN: Thank you, Suzie, for your presentation on the work that Accoras does. I want to come to collaboration and coordination amongst service providers. Hearing about the range of programs you do, it is amazing and terrific work. In another capacity I am a specialist physician in addiction medicine. We see a range of clients or patients over time—people who have serious mental health and/or alcohol and drug dependency. As a clinical person, and I know the member for

Greenslopes in his nursing capacity would appreciate this as well, you can put a lot of time into getting people detoxed from alcohol and drugs through rehabilitation and then stabilisation of a whole lot of conditions. You get to a period where they have had two or three years of those issues. They are then well and truly on track and their health is stabilised. The big issue then is how you get them into employment. I want to specifically ask about employment support agencies, job providers and the services that you provide. What can government do to try to highlight what exists out there and connect all of those bits? What I have experienced is that there is a period when people have not been in employment or in education and training, particularly for young people aged 16 to 18 or 17 to 19 years. It is hard to get them that first opportunity when they have had to put in all of this work to get on track and stabilise their health. My question is this: what can be done to highlight services like yours that exist out there? What further can be done with job providers, employment services and agencies to help those people?

Ms Lewis: I am a firm believer that every mental health service should have an employment program embedded within it. We know that employment keeps people well. If someone is living with a mental illness, sometimes the advice is that they should work on their recovery before finding employment. What we actually find is that if people can find employment it helps fast track their recovery.

At Accoras we are the lead agency for headspace Inala. We have embedded an IPS service, an individual placement and support service, so we are getting young people with mental illness into jobs. That is a model that I would strongly encourage having a look at. The way that works is you have specialist employment workers who are mental health informed and work with young people. They identify what would motivate the young people, what they would be good at and where they could succeed. They go into the community and build relationships directly with employers to create opportunities for those young people. We are fortunate we have a very good service. We are the equal rated best service in the country. Forty per cent of the young people who come through IPS end up in sustainable employment.

Dr ROWAN: So you embed those employment programs and providers in mental health services and presumably also in alcohol and other drug services as well.

Ms Lewis: Yes.

Mrs McMAHON: One of the things I picked up from your opening speech, also noting that you run your ParentsNext program, is addressing some of the needs around intergenerational trauma. I was wondering how you position yourself in that space. Obviously, working and identifying that hopefully works to prevent the cycle of mental illness, vulnerability and so on from becoming a problem in one more generation's time. Can you tell us how you work with parents and young children and where they go after finishing that program?

Ms Lewis: I think intergenerational trauma is one of the greatest challenges but also one of our greatest opportunities. When we think about the work we do with families, an individual mental health intervention will really struggle to touch on that. I have seen really great results from long-term psychotherapy with parents who have carried trauma from their parents and further beyond. If we are talking about communities, it really is strengthening the entire community, providing resources, bringing opportunities to communities. I suppose a useful example of something we are doing to try and disrupt intergenerational trauma is an infant mental health program. At Accoras we try to identify where people are not receiving services and address those gaps. Through retained earnings we have self-funded a mental health program called ABC, Attachment and Biobehavioral Catch-up—

Mrs McMAHON: When you said people are not accessing services, are you talking about a young parent who is falling through the gaps of all those check-ups and Child and Youth Health Services?

Ms Lewis: That is right. You mentioned ParentsNext, which is a pre-employment program that is required. If a parent is on a parenting payment they are required to engage, which means we can identify parents who may not choose to voluntarily engage with other support services or child development services. We can offer them something like ABC, where we go into the home once a week and support that parent to learn how to safely and in a nurturing way interact with their infant, engaging in the kind of behaviours that build a secure attachment that help the baby learn to safely explore their world and to feel loved and delighted and secure in their relationship with their parent.

We took ABC, we funded it, we developed it up and then we made it possible for parents to do that as part of their ParentsNext pre-employment plan. So instead of maybe doing a TAFE course or something like that, they could engage in the ABC program and build a relationship with their children. We were very fortunate with that program. When we talk about wanting to integrate and coordinate,

we have not done that alone. We have done that in partnership with the Queensland Mental Health Commission, the Queensland Family and Child Commission and the Department of Children, Youth Justice and Multicultural Affairs, among a number of others. We really want to advocate for systemic change in how we approach infant mental health for highly vulnerable families, not just us doing one thing off by ourselves.

CHAIR: You talked about the need for cross-agency coordination. I have engaged a bit in attempting to get various government departments to talk to one another. Particularly when you go from one level of government to another, it can be very challenging at times for a range of reasons. Is there scope and capacity to come at that problem from a different angle; that is, to look at some sort of person-centred case management or support so that we follow the person rather than trying to get government departments to come together?

Ms Lewis: Where someone is funded and resourced to support a person or a family and to make those connections happen, that does happen very well. I think it is difficult because if there is not a top-down approach at the same time, those roles end up inevitably being a bit personality based. Then when that person moves on, all the gains that happened at a systemic level with different organisations and agencies working together can be lost very rapidly.

CHAIR: The Productivity Commission report indicates a preference for regional mental health plans. They seem to anticipate really only a role for the PHNs and the HHSs. Would a planning process of that nature, which had more of a broader remit and involved not just other government agencies but the community sector and federal government agencies, be more of an effective tool, do you think?

Ms Lewis: I truly believe that is absolutely essential. Government controls so much of the funding and the levers. The private sector seems to deliver most of the mental health interventions from mild to moderate, increasing into more severe now as services get overwhelmed and people cannot get seen elsewhere. Having mechanisms like PHNs and peak bodies and advocacy groups working to coordinate care where they have the reach and they have the relationships—it would be amazing to see PHNs and HHSs having the opportunity to work more closely together. We work closely with Brisbane South PHN. Something they have done really well when looking at commissioning a couple of new programs is including the requirement to work cross-sectorially. Do not just work with other mental health services, do not just work with other NGOs, but pull in education as well, pull in housing as well, pull in youth services and community services; if you are not going to do that, we are not going to fund you. I think there are opportunities there.

CHAIR: I will never forget meeting a chap in social housing who had just moved in and he did not have any furniture or food in the fridge. He told me he had schizophrenia. He had not been connected into any local services. He had a house—that was great—but there was obviously a lot lacking there. In your early intervention programs in schools, in terms of early parenting, we have heard a lot about the missing middle between when people are diagnosed and then when they usually get help, which is via an emergency department. Are organisations like yours able to provide more services in that early phase for a person who has been diagnosed so that we can perhaps divert some of those people away from acute mental health services?

Ms Lewis: Yes, we are. That is very much our goal. Most of our funding in that area is in the child and youth space, so kind of zero to 25. It is an explicit goal of our programs that we want to keep people out of emergency departments and state mental health services, which is why we have to look at all areas of their functioning. If we just treat their mental illness but we do not look at their housing, their ability to engage well with education, then eventually they are going to cycle back.

CHAIR: Are you aware of the wellness or safety hubs, I think they have called them, which have been commenced in Victoria?

Ms Lewis: I know a little bit about them. I have never set foot inside one, but I have seen what they are working to achieve. I agree that having a one-stop shop where all service needs can be met and an actual genuine 'no wrong door' option for people where you can walk in is a good idea.

CHAIR: You talked about the need to get better value for our existing funding. We certainly have had all of these folks coming along and suggesting all of these new models of care and all of these things that we should be doing. Do we have any longer-term data around where these programs have been rolled out that might show us they are actually working, or are we simply funding another new model of care that we will be here in five years or 10 years critiquing, saying we need to go in different direction?

Ms Lewis: Every time we try and do something brand new we end up learning an awful lot of lessons that we try and incorporate for next time. One of the things that we have yet to do really well is co-coordinate. I am not sure about new models of care, but I am certain that if we can find ways to

talk to each other more frequently while we are looking after individuals and families and communities and make sure we know what each other is doing and we are working towards the same goals, we will get better outcomes.

Mr MOLHOEK: Thank you so much for joining us today. I have to say, I am just a bit overwhelmed by your knowledge and your understanding of the issues. I think you are a remarkable young woman. The intellect that you have brought to some of the issues is just amazing. You talked about the fact that every recovery program should include pathways. Can you tell us a little bit more about the employment pathways and opportunities that you create—I think you said through headspace at Inala?

Ms Lewis: Yes. One of the things that we find with our IPS youth employment service is the people who staff that do not spend a whole lot of time in the office. They are out walking in and out of businesses and shops and factories, having chats with the owners and the managers, talking about the benefits of working with young people with a mental illness. I think a lot of time employers might feel a bit intimidated, like they are taking on a problem. Where there is a really good fit for the young person and the business, what they end up with is a hardworking, loyal employee who will stay with them for years and years; someone they can train up and work with for a very long time.

The kinds of accommodations that are required for a young person with a mental illness are not actually that great. It is just a bit of flexibility and understanding that mental illness might wax and wane and there might be times when they cannot work as much as other times. Where there is a relationship in place with a mental health service and the support is there so the employer does not feel like they are navigating that alone, there is much more of a readiness to take on these young people and give them a chance. When these young people are given a chance, because they have their mental health care in place, because they have the support of an employment specialist, they are succeeding.

CHAIR: I would like to thank you very much for coming in. I think the information you have provided here this afternoon has been extremely useful. The committee would also like to thank you and all of your staff and volunteers for the work you do. The last couple of years must have been very tough with COVID. We do appreciate everything you do. Hopefully we can get a report and some recommendations together that will prompt the government to think about actions that might improve the lives of people experiencing mental health or alcohol and/or drug issues.

Ms Lewis: Thank you so much for the invitation and the opportunity.

DAVIES, Ms Angela, Senior Peer Coordinator, Lived Experience (Peer) Workforce, Gold Coast Hospital and Health Service

SANDERS, Ms Michelle, Team Leader, Lived Experience (Peer) Workforce, Gold Coast Hospital and Health Service

CHAIR: Thank you for your patience. I welcome Michelle Sanders and Angela Davies. Peer workforce is an area that we as a committee are greatly interested in. We really appreciate your time here. Would you mind making a really brief opening statement and then we will go to questions.

Ms Sanders: Jingeri. We would like to acknowledge the Yugembeh speaking people on whose lands we live, work and grow. We pay our respects to elders past, present and emerging. We also acknowledge other Aboriginal and Torres Strait Islander people who may be present today. We acknowledge and value the perspective of the consumers, carers and families of our public mental health services and all people, such as ourselves, living with mental health challenges or difficulties associated with the use of alcohol and other drugs. We recognise the widespread impacts of suicide within our community and will continue to strive to create a public health service that compassionately cares.

My name is Michelle Sanders and I am here today with my colleague Angela Davies. We are employed in lived experience leadership positions within Gold Coast Health's mental health and specialist services. We are part of the relatively newly recognised evidence-supported workforce in mental health and alcohol and other drug services of professional peer and carer peer workers. The terms 'lived experience workforce', 'peer and carer peer workforce' or 'consumer and carer workforce' are often used interchangeably to describe our profession, which has grown out of the naturally occurring social supports that people draw on when connected by similar life-changing experiences of mental or emotional distress, service use, recovery and healing or the impact of walking beside and supporting someone through these experiences.

Some of the key messages from our Queensland Health submission to the inquiry are that people living with mental illness and problematic substance use experience significant stigma, including discrimination across health and other aspects of their social and community life, which creates barriers to seeking treatment. The protection of human rights, safety and high-quality care in a system where all participants are well informed are paramount. There needs to be more partnerships between people with lived experience and clinicians to reduce or eliminate the use of restrictive practices or coercion. There needs to be continuing recognition of the role and value of the lived experience peer workforce as part of the treatment and care team responding to the needs of individuals, their families and carers.

The National Lived Experience (Peer) Workforce Development Guidelines, released last year, state—

> Lived Experience workers provide a resource for change. Regardless of the job position, each worker is a 'change agent' providing a resource to support personal change in service users and cultural and practice change in the service. A core purpose of the Lived Experience workforce is to help service providers to understand everything in the mental health care through the lens of living experience and recovery. Workforce development is not simply about creating new jobs; it is about the internal organisational and individual professional development that shifts the focus to the experience of mental illness.

Over my 16 years working in identified professional lived experience roles with Gold Coast Health and prior to that many years as a lived experience representative, educator and advocate in the Queensland community, I have been a keen observer and an active participant in the development of our peer and carer peer workforce across Queensland, within health services and in the community sector. I see much that is working very well. We have examples of health services, notably Metro South and Metro North hospital and health services, that have had the forward-thinking initiative to create lived experience leadership positions at director level. I have seen the implementation of new models of service delivery that place peer workers as the principal workforce, such as community care units in Metro South that spearheaded their growth to where it is now as the largest peer workforce in public mental health in the Southern Hemisphere.

I applaud the integral inclusion of peer workers in settings in which we deliver care to those in mental health crisis, such as our own Yalburro angabah unit at Robina Hospital here on the Gold Coast, which is the first crisis stabilisation unit of its specific type to open in Australia. The rollout statewide of mental health crisis safe spaces, peer workers in emergency departments and short-stay mental health crisis units all provide increasing access to professional peer support. I see opportunities everywhere for the development of peer and carer peer workforce as a vital part of the staffing profile for all mental health, alcohol and other drug services and am inspired by the progress

being made to support our workforce by the continuing uptake of Certificate IV in Mental Health Peer Work, and new resources being allocated to assist students, such as scholarships being available and mentors employed in the TAFE context.

I am heartened by the formation of the Queensland Lived Experience Workforce Network, QLEWN, coordinated and supported currently by Brook RED, a fully consumer-run community organisation, and Metro North Primary Health Network. This network is inclusive for all those working in Queensland who identify themselves as lived experience workers. I am grateful for the work of my peers, such as Dr Louise Byrne, in the academic settings who have collaborated with those of us working in services and the community in order to create supporting guidelines funded by our Queensland Mental Health Commission and the national Mental Health Commission, such as the Qu*eensland Framework for the Development of the Mental Health Lived Experience Workforce* and the National Lived Experience (Peer) Workforce Development Guidelines. Many hospital and health service lived experience teams have also developed their own growth strategies. As a collective, Queensland Health has a statewide framework for the development of the peer workforce in Queensland public mental health services.

As our new workforces grow in Queensland and Australia-wide, we see the need for leadership and support. In the past few years we are recognising the vital importance of and immediate need for access to specialist peer practice supervision, and there have been a number of guidelines and strategies produced in other states as well as the production of our own Gold Coast health peer practice strategy, which is informing the Queensland mental health supervision guidelines calling for the resourcing of supervision as a priority area. Without robust attention to resourcing lived experience leadership, training and supervision, there is a risk that lived experience workforces will have difficulty thriving and, hence, fulfilling the huge potential they have to lead cultural and service change in organisations and communities. Thank you for inviting us here to today. We are open to any questions you have.

CHAIR: In your opening statement you talked about the fact that the involvement of people with lived experience in the development, planning and implementation of services could lead to a reduction in restrictive practices. How would that occur?

Ms Sanders: Angela, would you like to answer that one? You are working on the seclusion and restraint committee.

Ms Davies: I am here as a support person. Am I allowed to speak?

CHAIR: Yes, of course you are.

Ms Davies: Could you repeat the question?

CHAIR: The statement was made that by including people with lived experience in the workforce, both in planning and delivery, we could reduce restrictive practices. How would that occur?

Ms Davies: I think that we need to focus not on reduction of restrictive practices but on elimination of restrictive practices. That begins by re-thinking what we think we know about people with mental illness. I would say that the service system is really set up on the medical model of service delivery: that there is an assumption that people with mental illness are either a danger to themselves or a danger to other people; that people need treatment and care provided by various professionals; and that what is done to them is always in their best interest. There is a lot of evidence from people with lived experience that often that control and intervention does an enormous amount of harm. By shifting the perspective from 'what's wrong with you' to 'what's happened to you', developing services that actually support people with their needs from a trauma informed and recovery oriented perspective and building those services with people with lived experience and clinical professionals in mind, we would have a very different service and a very different service system. Like Michelle said, people with lived experience in the workforce—we are change agents.

Ms Sanders: I am happy to add to that. Specifically, you are asking what is different about the peer workforce that would help to reduce coercion, restraint and seclusion. A lot of that is around the fact that, because peer workers and carer peer workers have similar shared experiences, they are very good at developing a fast rapport with people. We know this happens in inpatient units, in crisis settings and in emergency departments. Peer workers are extremely successful in building a fast rapport with people and being able to empathise to a level and de-escalate. They are very skilled in de-escalation. If they can connect with someone and gain someone's trust early then the person is likely to settle, which reduces the 'need' to have people coerced, restrained and secluded.

We are finding in our crisis stabilisation unit, which as I said was the first of its kind in Australia, that we have a significant number of peer workers who are basically what you would call on the floor and the clinical professions might come in and out to do assessments. It is the peer workers who are

on the floor doing the vast majority of care as far as the time spent is concerned. In the whole time we have had that unit open there has been one episode of short seclusion. Usually it is a lot higher, especially in the crisis space. This is a crisis facility so we see that.

We find that peer workers are also good at taking the time to understand what the triggers are for a person. Because we have been through similar experiences we may have a similar understanding of what is happening. That is even the case with the language we use to describe what is happening. We can understand better what is happening for people. We then do a lot of liaison with the clinical teams—this is what is upsetting the person, this is what they need, this is what they are interpreting. It is about being able to recognise early that a person is starting to feel anxious and starting to feel triggered and that there are things that are important to this person that need addressing. If peer workers are there and can address them early then that reduces seclusion and restraint.

It is also about just having more people on the floor. A lot of our clinicians take issue with the fact that they would like to spend more time with people but there are more and more obligations for them to spend time on documentation, key performance indicators and all sorts of things that separate them from delivering care. At the moment, we have the option of having peer workers and carer peer workers who come in and spend the majority of their time with people.

CHAIR: If the peer support workers stick around longer then the bureaucrats will eventually find ways to fill up their time.

Ms Sanders: We are trying to avoid that happening.

CHAIR: It is an area that interests me. Probably one of the most horrible things that I have had to deal with is being involved in restrictive practices back in the 1980s. My experience is outdated. I think about non-mental health settings. When I started it was nothing to tie patients into beds or tie them into chairs. The liberal use of chemical restraints was common well into the 2000s. These days, at least to a certain extent in Queensland Health in physical health settings, there has been a lot of work done around how to manage challenging behaviours. In fact, the standard practice now is to special a patient to try to manage those behaviours with one-on-one care. I think that goal of eliminating restrictive practices is an extremely good one. I think health professionals would support that.

You talked about academic Louise Byrne who has done some work in this area. One of the questions we have asked in other places is: do we need to try to define a scope of practice for peer support workers and standardise some sort of training or development processes? You talked about supervision. That is another aspect of professional practice.

Ms Sanders: The two documents that have come out—the Queensland development guidelines and the national development guidelines—pretty clearly outline what the scope of practice is for peer workers. There are companion documents that go with that that outline the role. I have some of the documents here if anyone wants to have a look at them. They outline that. That kind of work has already been done by lived experience academics, led by Dr Louise Byrne and her team.

The reason they have been doing those—and they were commissioned by the Queensland Mental Health Commission and the National Mental Health Commission—is that there needs to be some understanding for organisations and for health of what the role of a peer worker is. I know that I personally started at a time when there were no role descriptions. This came out of things like the Burdekin report into abuse of people with mental health challenges. They just said that we need to have inclusion. We came in with no role descriptions and no idea. They just said, 'You need to be here.' It was a big process to come in with nobody knowing what we were there for, but knowing we need something.

We have come a long way from there as far as having lots of outlines. We have the guidelines there. The Certificate IV in Mental Health Peer Work is statewide accredited training that is available. There are lots of smaller training courses as well. At the moment we have not gone past the certificate IV. There are still significant issues with rolling out that qualification. We have seen a lot of training organisations that have not necessarily followed the obligation to make sure that the trainers and assessors are experienced peer workers and carer peer workers. That has led to difficulties with the quality of training.

We have seen that a lot of training organisations just want to get their regular trainers to deliver a course that they do not know about. It is a bit like getting a builder to deliver a course on baking. Unfortunately, that has been a bit of a hurdle. We are still working in close partnership with training organisations and specifically TAFE to make sure that we improve that quality. We are often the industry advisers to help them.

We have recently had some success with statewide funding being made available so that we can have some coordinators and mentors, especially in TAFE, to help students. We thankfully have a fair few guidelines. It is more around the resourcing and following what is in those guidelines that have all been developed in the last year or two. They are recent and have been developed in a collaborative way. The writers and developers have come to us. We have all been involved in consultation.

Ms Davies: Around scope of practice, peer work is a values based profession. We work with peer support values, principles and ethics. People who come into these roles bring with them not only their lived experience and being able to use their lived experience in an intentional way but also many other skills. When we are talking about scope of practice, there are a number of tasks that peer workers can take on. It is not so much about giving people guidelines about what they can and cannot do but helping them to understand why we do things the way we do them. I think that is through education more so than something like a scope of practice document.

Dr ROWAN: Following on from scope of practice and training, with peer support workers being engaged in service planning discussions not only within the Gold Coast Hospital and Health Service but also statewide, do you have any comments or recommendations about what you are seeing here on the Gold Coast and what else could be done to engage that repository of knowledge, skills and expertise into service planning not only within health services but also within primary health networks and outside the public system?

Ms Sanders: I will let Angela answer that question because I think you are talking more about the related field of consumer and carer inclusion and participation. We have the professional lived experience peer workforce and then we have consumer and carer inclusion more broadly. It is about people being included as partners in their own health care plus that representation, as you say. Angela has just come from helping to develop the new Queensland lived experience peak body. I will hand over to Angela.

Ms Davies: One of the things that we noticed during the development of the peak body is the role of power and power dynamics. What people with lived experience are telling us is that they need a much longer lead-in time to be engaged in these pieces of work. As people who are employed we have the luxury that, if we do not understand something, we might bump into somebody in the corridor and we can run it past them. We can say, 'I do not really get what that meeting was about. Can you explain it a bit more?' We have all the background knowledge about why something has come about. Then often we are inviting people who have lived experience to bring their own expertise to the situation; however, they do not have background knowledge. We are remunerating them by the hour. We are providing them with support, but they have to ring up and access that support. What they are saying to us is, 'We need a lot more time to develop relationships with the people we are going to be co-designing and working with. We need to get to know them on a personal level. We need to know what makes them tick. We need to understand what this piece of work is about and why it is so important to be able to do that piece of work.' When they come to sit around the table and make decisions together, everybody feels that they are on an equal footing or as equal as possible.

Ms KING: It has been a revelation to me through the course of this inquiry to hear about the work and the impacts of lived experience peer workers so thank you very much for what you do. We are all learning so much. I want to ask you a bit about the journey of a person who might come into a service as a person experiencing mental ill health or distress and then goes through the service and eventually goes onto become a peer worker. We have heard from peer workers in many different settings through this inquiry now. One of the things that has struck me always, but I have never had a chance to ask, is whether for a person who is experiencing mental ill health or distress seeing peer workers on the ground in those care settings—that is, it is not just a pathway through to wellness but also a professional role for a person who has experienced mental illness—is a giver of hope that might drive toward recovery in and of itself?

Ms Sanders: We actually get a lot of requests from people when they come through. We have got peer workers in our emergency department, we have got them in the Crisis Stabilisation Unit, and we have got them in the units and the community as well. When people have that access and have time with peer workers, a fair percentage of them ask about and are interested in peer work itself. They often give us a lot of feedback that it was really helpful. We get lots and lots of compliments about how effective and helpful peer work was. From there, a fair percentage of people want to know how they can become a peer worker. I would not say everyone but some people go on to become peer workers.

We generally provide people with some information around consumer and carer representation. We always encourage people to focus on, firstly, their own wellness and recovery but we give them something to think about down the track if they request it. We would never necessarily

say to people, 'You should be a peer worker' or 'You should be a rep.' It often comes from the person. We have fact sheets on our consumer and carer representative program, we have fact sheets about peer work and carer peer work, and we provide that to them.

If they ask what qualifications they need, we will give them information about the Certificate IV in Mental Health Peer Work. We will say, 'This is for you to consider down the track if you are still interested.' What often happens is that people might in the moment feel like they want to be a peer worker but later on that can change, and that is absolutely fine. They have our contact number and we do have people who then call us and we meet with them. On the Gold Coast, we have the Gold Coast Mental Health Peer Workforce Network, and other areas have similar networks. It is a network of professional peer workers, voluntary peer workers, students who are at TAFE doing their Cert IV in Mental Health Peer Work, and some private lived experience consultants. We invite people if they want to join the rep program and they can see if it is for them.

We give them a lot of information about different avenues they can explore, and we encourage people to do things. Health Consumers Queensland has consumer representative training. If they are really interested, we encourage them to get involved in peer support groups that are happening in the community. Those are the things that basically help you if you want to get a professional job because they show that you have attended different training and different forums and you have connected into the community. Basically, that is our first job if someone is interested—that is, to connect them in with the community.

Mr MOLHOEK: Michelle, you mentioned briefly in your opening address the Crisis Stabilisation Unit at Robina. I assume that is the new unit that has just been set up. It would be helpful to understand the role of that unit, what is different having it there now and how effective it has been.

Ms Sanders: We are getting lots of really positive feedback from the people and their families and carers who use that unit. This unit is, I guess, an alternative to emergency departments. From the time that I have been through emergency departments with myself and family members and also from working, there have always been a lot of challenges with people coming into emergency departments and having to wait in emergency departments and be assessed in emergency departments. One of the reasons we first started putting a peer worker in an emergency department was to be able to assist in giving at least some access to someone who can ease some of that time by having a therapeutic conversation and peer connection. This stemmed out of that. We know that the community really wanted something different because we had lots and lots of feedback from the community. It was a collaborative approach, with lots of people from the community supporting that.

It is a purpose-built space that is next to the emergency department at Robina Hospital. Suitable people in mental health crisis who do not need to be in the medical area of the hospital can come across there. They get their assessments. Rather than staying in the emergency department and having mental health clinicians assess them in the emergency department, they go into a purpose-built facility, which is a more homelike environment as far as having more comfortable settings. There is plenty of space so people do not feel like they are trapped in a really small area with other people who are also in crisis.

It is a different model in that we have at the moment maybe eight peer workers who work in there. They work 24-hour shifts, so this is also a different part of expanding their scope. This is the first time we have had peer workers on the Gold Coast. In the community care units at Metro South, they have had peer workers who work 24-hour shifts as well.

Ms KING: So do they sleep on site?

Ms Sanders: Who?

Ms KING: Or do you mean the peer workers are available 24/7?

Ms Sanders: Yes, so they are doing 24-hour shifts.

Mrs McMAHON: So they are not working a 24-hour shift.

Ms KING: I was a bit worried there for a second.

Ms Sanders: No. It is a much more therapeutic setting. What people have explained before—and certainly I have experienced this myself—is that, if you are in mental health crisis and you are coming to the really busy, stressful environment of an emergency department and then you have to wait for a really long time, it is not a very good setting to actually calm an emotional crisis in. The purpose of Yalburra Angabah, the Crisis Stabilisation Unit, is to provide an actual setting that is conducive to a reduction of the mental health crisis. Those peer workers we have there are an integral part of providing that kind of environment with the interventions that they offer.

Ms Davies: People are offered a shower when they come in, for example. There is a washing machine if people want to wash their clothes if they have not been in a home environment for a while. There are clean clothes for people to access. There is a kitchen where people can make themselves hot drinks or cold drinks and help themselves to sandwiches and biscuits. Hot meals can be ordered for people. There are beautiful recliner chairs and an outside area. There is lots of space for people to be in. I think we are getting some daybeds for there as well.

CHAIR: I would like to thank you both for coming in. We did hear from the peak body, but it is really interesting to hear from people at that coalface level. The information and experience you have shared with us today will help to inform our report and our recommendations going forward, so thank you very much for coming in.

The committee adjourned at 3.37 pm.