MENTAL HEALTH SELECT COMMITTEE

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

Staff present:
Dr A Beem—Acting Committee Secretary
Ms M Westcott—Assistant Committee Secretary

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

TRANSCRIPT OF PROCEEDINGS

THURSDAY, 10 MARCH 2022

Brisbane

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The committee met at 9.02 am.

CHAIR: Good morning. I declare this public hearing of the Mental Health Select Committee open. I would like to respectfully acknowledge the traditional owners and custodians of the land on which we meet today and pay our respects to elders past and present. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander people whose lands, winds and waters we all share. I would also like to acknowledge the lived experience of people with mental health issues, alcohol and other drug issues, or experience of suicide.

I would like to introduce the members of the committee. I am Joe Kelly, the member for Greenslopes and chair of the committee. Mr Rob Molhoek, the member for Southport, is the deputy chair. The other committee members are: Dr Christian Rowan, the member for Moggill; Ms Ali King, the member for Pumicestone; Mrs Melissa McMahon, the member for Macalister; and Mr Barry O'Rourke, the member for Rockhampton. Ms Amanda Camm, the member for Whitsunday, is not joining us today.

The purpose of today's proceedings is to assist the committee in its inquiry into the opportunities to improve mental health outcomes for Queenslanders. This is a proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. Only committee members and invited witnesses may participate in the proceedings. Witnesses are not required to give evidence under oath or affirmation, but I remind witnesses that intentionally misleading the committee is a serious offence.

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RENOUF, Ms Jessy, Youth Advocate, Queensland Family and Child Commission

TWYFORD, Mr Luke, Principal Commissioner, Queensland Family and Child Commission

CHAIR: I now welcome back representatives from the Queensland Family and Child Commission. I invite you to make a brief opening statement and then we will go straight to questions.

Mr Twyford: I would like to start by also acknowledging the traditional owners of the land, the Jagera and Turrbal people, and pay my respects to their elders past, present and emerging. I am joined today by Jessy Renouf, one of QFCC's youth advocates and someone who is keen to talk to you about mental health services in Queensland. I would also like to acknowledge the committee for the private hearing they had with five of our youth advocates.

Across research and literature, there is growing evidence suggesting a high prevalence of mental health conditions among our young children. The Australian Child and Adolescent Survey of Mental Health and Wellbeing found 14 per cent of four- to 17-year-olds had had a mental health diagnosis in the previous 12 months. The Australian Institute of Health and Welfare reports that mental and substance use disorders, particularly anxiety and depression, caused the largest non-fatal burden of disease for children and young people aged 15 to 19.

In 2020 the QFCC surveyed more than 8,000 Queensland children for our *Voices of hope: growing up in Queensland 2020* report. Thirty-three per cent of these children told us that they had an emotional mental health condition. More than half were unaware of the mental health services that were available to them and only 13 per cent had used a mental health service. Worryingly, 39 per cent said that when they needed support they had not sought it and had kept the problems to themselves. As a society, we must acknowledge that failing to support the mental health needs of others not only damages lives but also damages our community and damages future generations.

Sadly, the number of young Queenslanders who are taking their own life is increasing. Over the last five years 132 Queensland children have taken their life. Tragically, in the last financial year, there were 30 confirmed or probable suicide deaths. We must act when young people tell us what we can do differently.

Last year, the QFCC commissioned the Young Minds Can't Wait QFCC Hackathon. Children and young people told us that they had difficulty accessing services due to costs, stigma and location, while 62 per cent said they lacked the confidence to contact mental health services. Others faced barriers such as not having their own Medicare card or they were afraid that their parents would find out. Demand for mental health services has long outstripped the available supply in Australia. Young people advised there is currently high demand for psychology services and it is common to wait over six months to see a psychologist. They told us of examples where the poor reaction of teachers and adults had exacerbated their problems, made them feel lonely, diminished their hope and made them less likely to seek help.

To support children's mental health, we need to look beyond the scope of traditional suppliers of mental health services. We must include families, school teachers, people who work in education and health, and other settings where adults have trusting relationships with young people. We must all contribute to supporting the mental health needs of Queenslanders. When we ask young people about improving mental health support, 50 per cent recommended adding understanding mental health to the school curriculum, 31 per cent recommended providing mental health training for teachers, 38 per cent recommended improving access to services and funding including through child focused service design, and 38 per cent recommended greater promotion of services.

In conclusion, if you want to make a positive difference, we must intervene earlier. One study to understand the age of onset of mental health conditions found half of all lifetime cases start by the age of 14 years and three-quarters of all conditions start by age 24. Mental health support must be provided to the children and young people of Queensland. Interventions aimed at prevention or early treatment for mental health conditions need to focus on children, and we must make sure they are available and accessible for these people. Mental health services must be designed to meet the needs of those who need it. This requires us to be more creative in how we listen to and act upon the diverse views of those who are using mental health services. On that note, I hand over to Jessy to share her perspective and I look forward to assisting you with your inquiry.

Ms Renouf: Before I begin, I would also like to acknowledge the traditional custodians of the land we are meeting on today, the Turrbal and Jagera people, and pay my respects to elders past, present and emerging. I am a youth advocate member for the Queensland Family and Child Commission Youth Advisory Council. I am 19 years old and have chosen to appear at this hearing because I am extremely passionate about mental health due to its significant impact on every single Queenslander. I have many lived experiences around mental health, such as studying a bachelor of psychology and justice as well as working as a receptionist in a private psychology clinic for over a year now.

I believe the biggest challenges to youth mental health in Queensland are minimal education and limitations to accessibility around mental health and its services. Firstly, I strongly believe most Queenslanders, especially youth, do not have enough knowledge around mental health services. This includes not knowing what resources and services are available to them and not knowing how or when to seek care. Personally, I did not know any of these things until I had worked in the field myself. I believe this is because there has been minimal education in schools and lower awareness around these topics which can lead to many young Australians not receiving any care when they can or when they really need it.

Secondly, I firmly believe there are many limitations to accessibility for mental health services and resources, such as wait times and fees. To begin, at most clinics such as the one that I work at, for new clients it can take up to months to get in for an appointment, let alone to see someone who is trained in your area of expertise or need—for example, children—and can provide the most effective treatment for you. Additionally, fees for a psychologist can be extremely expensive, even with Medicare rebates which only cover so much and so many sessions. Yes, I do acknowledge that there are services that target younger Australians and are bulk-billing. However, these services are in extreme high demand and have even longer waits as a result. Because of all of these limitations, it can mean that those in need may not be receiving adequate care when they need it or at a price they can afford, which can consequently lead to even further issues.

To address these challenges, I respectfully ask the committee to consider the following solutions. For education, a solution is to create and promote more effective resources to assist young Australians to manage their own mental health and wellbeing. This could include online educational programs and school programs targeted for youth around what mental health is, how to manage your

mental wellbeing and what additional services are available to them. This would be extremely effective because it is easily accessible by being online or in schools. Knowledge would be taught to young Queenslanders to help them or others if they need it and can assist those in the short-term while waiting for a psychology appointment.

Another solution for accessibility is to propose that Medicare offer at least 12 rebated sessions a year. This increase from the current 10—excluding everything going on with the COVID-19 policy as well—would allow clients to be able to see their psychologist for a rebated or bulk-billed session at least every month. This would be really beneficial because psychology is a gradual process, and to limit this is not in the best interests of our clients or their mental health.

Young people need the right support to manage their mental health. Queenslanders need to know what mental health is, what techniques they can use to improve their mental wellbeing and what services are available to them. Schools need to provide this information in a regular and meaningful way as an immediate priority. Young people are in need and we must act now. Thank you for the opportunity to share my views with you all today.

CHAIR: Thanks, Jessy and Luke. Luke, you mentioned three things as being barriers to access—cost, stigma and location. Jessy, you talked about the need for access to resources to assist young Australians to manage their own mental health. There were a number of suggestions around curriculum, training for teachers and promotion of services. We have headspace. We have just increased a trial of GPs in schools. There is a program that has just been announced that has come out of Orygen and Patrick McGorry's work, Q-MOST. The New South Wales government has a pretty good online program called MindSpot. It seems like there are a lot of things starting to happen in the areas you are talking about. Does more need to be done? Do we need to give these things time to roll out, or are we on the wrong track in relation to what we are doing?

Mr Twyford: From my perspective, we are certainly on the right track in terms of thinking differently about mental health and how we as a society respond. I think the key message from the work we have done over the last few years is that there needs to be a diversity of responses. There is not a silver bullet. Every individual needs a tailored response. For some, that is a psychologist on a regular routine basis. For others, at the earlier end, it can simply be a peer network of support where it is safe and okay to talk about their feelings and what they are going through. I agree with you, there are a lot of new initiatives emerging. There are some amazing online platforms that people are promoting to young people. I think that that is a response from those that can provide help. What we need to consider is the people that need help and how we can make them feel safer around their own shopping for the appropriate solution, making sure that people who have depression or anxiety, that they are comfortable in seeking support, and that when that support is offered it is there at the time and in the way that they need it. I think we are still learning what that might be. Headspace is a wonderful organisation and does amazing work for the people who connect with the way that headspace operates, and they, as an organisation, are learning how to respond, like all organisations, to the clients who are not having the best experience. Equally, there are online apps and applications that young people and others are using that, for them, meets all their needs.

What I am trying to say is that we need a diverse array of service responses to all people with mental health issues, but a key factor in that is letting people know what is available, letting them test and try and find the right solution for them. I worry that sometimes our narrative and our promotion of services is not reaching the people we actually need them to reach.

CHAIR: Jessy, I want to ask you a question about stigma. You talked about the reaction of teachers et cetera. As a registered nurse, when someone engages in behaviour that you find challenging or is considered to be broadly socially inappropriate, people do react in what has previously been considered a normal way. How do we get over this issue around stigma? What do you think needs to happen to start to reduce the stigma for people who are affected by mental health issues or alcohol and other drug issues?

Ms Renouf: In regards to stigma, I completely agree with what you are saying as well in regards to it. I definitely think we have come along in an extreme way. We have become extremely progressive around mental health. I think people are talking about it a lot more. In regards to your question, I think a way to reduce stigma is to talk more about it, especially with younger people and even their parents as well. I know that in the past mental health may have been seen as very stigmatised, that it is a scary thing, but I think if we start with our youth now, especially with regard to all of the statistics we have as well which shows mental health issues usually arise in our youth, so from 15 to 19, I think what we need to do is speak more about it, especially in schools. Youth, people who are aged 15 to 19, are in school or early university. If we speak more about it in schools and raise awareness that mental health issues are a thing and that it is okay to have them, I believe that the stigma would also decrease as well.

I think a huge area around stigma as well is saying that, 'Oh, this is what mental health is. It is when you may have anxiety or depression.' Everyone sees that as an extremely negative thing. Obviously it is not a good thing to have, but I think we need to put a positive spin on it in terms of if you have anxiety or depression, it is okay, and there are ways for you to manage it such as through these resources and things like that. Alongside talking in regards to stigma, we cannot just throw the issue at them and be like, 'This is what mental health is.' We also need to help them with techniques that they can use to improve their mental health being, as well as also what resources are available to them.

Mr MOLHOEK: Thank you, Jessy and Luke, for coming in and being part of our hearings today. I appreciate your time. I have so many questions. One of the issues that is exercising me a bit is why has there been such a huge increase in demand? It seems like there has never been so many services available. We have Kids Helpline, headspace, chaplains in schools—there are so many resources, yet we still cannot seem to meet the demand. I would be interested in your thoughts as to why demand is growing. It cannot just be COVID.

Mr Twyford: I do not have a clear answer for that, and I think if anyone does, we need to test the evidence they are proposing. I speculate that, as Jessy says, we have become more progressive as a society and people are more willing to talk about their mental health and, therefore, we see more need for services as it becomes a discussion and the discourse and the stigma starts to drop away. As Jessy was talking, I wanted to say that everyone has mental health. We have physical health, we have sexual health and we have mental health. I think we should reframe services for mental health much like gyms for physical health and draw analogies. There are a plethora of gyms and diets for physical health, but we still have obesity. I think we are in the mental health space seeing service responses emerge and programs emerge and good people doing good work, but with those statistics I quoted around early onset of mental health, diagnosis of very young children, increasing suicide rates, we are still on a journey of learning and research around what exactly we need to do. However, what we do know already is that we need tailored responses and that young people—all people—with mental health needs need a response that suits them. We cannot ask people with mental health to change themselves to suit the service we offer.

Mr MOLHOEK: All across the state we are seeing that there are significant shortages of services. It is not lack of money so much as it is lack of trained and qualified people. Is there a greater role for counsellors, rather than psychologists, in supporting mental health and should we be looking at ways to make general or mainstream counselling more accessible?

Ms Renouf: I definitely think that that could be a positive thing. In regards to the last question as well, yes, we are getting more progressive and people are recognising mental health, whether or not it is a diagnosis of anxiety or depression, in regards to physical health, that kind of thing. I think what is arising is that people are noticing that they need psychologists who can tend to their needs. For example, as well as what therapeutic approach they have, they may also have certain areas that psychologists cannot represent as well. For example, people who are part of the LGBTQ-plus community or people who may be Indigenous Australians do not have that representation. I think having more resources such as counsellors would be beneficial, as well as psychologists. However, I think that if we were to introduce more counsellors, they would need to be representative in themselves and in their training around the target audiences who are more likely to have mental health issues as well.

Mr Twyford: If I could add to that, I agree, I think more counsellors would certainly assist, but we need to approach this from a public health model and look at how do all people that work with young people improve their understanding of mental health and have the ability to offer support at the early end and then a graduated response up through our systems so that we can triage, for want of a better word, people's mental health needs with schoolteachers, sports coaches, or anyone in the community able to offer support, rather than a stigma, and that will eventually or hopefully lead to an intent to keep psychologists for those at the extreme end. That demand management across the system, I think, is critical if we are to make a difference across the state. Part of our calling for greater community awareness and education is exactly that: the earlier we can provide support and stem the growth of a mental health need into a crisis, the better.

There were 8,500 ambulance callouts in the last financial year for children attempting self-harm or suicide. That is a startling statistic. Clearly, in each of those cases, it reached a crisis point where ambulance crews were responding to difficult mental health needs. Our question should be both what psychologists could we make available in those circumstances and also what could we have done earlier as a society and a community for each of those young people.

Mr O'ROURKE: My question is directed to Jessy. In regards to your submission, Luke, around children in regional and remote areas accessing services and the shortage of workforce and things like that, I also noted in the report of the Australian Psychology Society, they reported 93 per cent of psychologists supported telehealth services for residents of Queensland. From a youth perspective, is telehealth a good option in our regional areas?

Ms Renouf: With my background being a receptionist, I get to hear the perspectives from psychologists as well. I know in regards to psychologists, they prefer in person, especially with youth, because there are lots of things that we are taught in psychology around body language and facial expressions which you are not really able to see as much if the consultation is via telehealth, especially phone. However, in respect of youth, personally, if I was offered a telehealth appointment I would love it especially in regards to accessibility as it is so much easier to go online and have a phone call or have a Zoom session with my psychologist. However, that is only my perspective. I think a lot of other youth would feel the same as me, but I think as well some people prefer in person because you can build that rapport a lot easier when you can see their body language and how they respond to you as well. It is half and half. I definitely think that the option of having telehealth is really beneficial for youth in particular, for those accessibility reasons.

Mr Twyford: If I could briefly add to that point, I think the issue of parental consent is a critical understanding in that matter. If a young person is willing to jump online or on the phone and seek support—it works for headspace and Lifeline and other telephone services—how do we extend that into Medicare rebated psychological and psychiatric services? That is an issue we need to resolve.

Mrs McMAHON: My question is to you, Jessy. I am guessing that you are the youngest person in the room right now, so the one with the most recent experience with schooling. You said things are changing and that you are seeing a positive, but could you tell us, from your schooling experience, what you saw in schools; what programs or education, if any, there was; if there was discussion about it not only within the curriculum but also amongst the kids; what you were hearing in regards to your recent school experience?

Ms Renouf: I graduated two or three years ago. To give some perspective, my high school was really good. I think all of the teachers were quite trained in mental health and they were very considerate around those issues. However, in regards to what programs were available, I think that there could definitely be an improvement, especially for days such as R U OK? Day. I know with our school we had an event. It was mainly that you would go along and they would talk to you a bit about mental health and then that would be it. I know especially with days like that it was not really beneficial because they were not teaching you much really. There were times that you could learn things, but I think that they are only one-offs. I know from the perspective of myself as well as other students, they were like, 'Oh, R U OK? Day,' but it was never really asking the question saying, 'Are you okay?'; they would be like, 'Well, maybe I am not okay,' and then it would be left at that. They would not really push for all of the resources or techniques that you can do to manager your own mental health.

In regards to other programs that we had, we did have some other days where we would have organisations come in and talk to us about mental health. However, to be honest, to the day today, I do not really remember exactly what that is. I think what would be more beneficial is to have programs that are ongoing, rather than a one-off day, where you get to learn about it, so that it gets formalised in your head because obviously at school you learn a lot of things. I think it would be beneficial to continue that and continue having a conversation.

Mrs McMAHON: If it was imbedded in the day-to-day curriculum, rather than just a visiting group that comes in occasionally?

Ms Renouf: Definitely.

CHAIR: One final question from the young-at-heart Dr Christian Rowan.

Dr ROWAN: Thanks very much, Chair. I was interested in your comments in relation to funded psychology sessions returning to 12 sessions per year. When the Better Access initiative was originally introduced federally back in about 2006 they had those initial 12 sessions and I think an additional six under certain circumstances for people as well. Then in about 2010-12 that all sort of changed. With the recommendation to go back to 12, would that be going back to what it originally was, which was recommending that the federal government consider going back to 12 sessions plus those additional six under certain circumstances? Is that what you were alluding to in relation to better access?

Ms Renouf: Yes, definitely. I reckon at least 12 would be good. If we can get it back to 12, I think that would definitely be beneficial. I know from my experience as a receptionist I have had people to whom I have had to explain this. Currently we have 20 sessions, so the initial 10 that you

get for the year through the Better Access scheme, like you were saying, and then obviously with everything going on with COVID-19 Medicare also has offered an extra additional 10. I definitely think raising it to what it used to be, 12 sessions, would be extremely beneficial because it is not even one session a month. Especially if we are trying to destigmatise health and say there are these services for you, but then you only get 10 sessions rebated. In relation to what I was saying in my opening statement around fees, some people do not have the money to pay for the full session outright if they are paying for their sessions. The same with even bulk-billing sessions. If they get 10 sessions and then after that they have to pay, it means that we are practically inhibiting them from receiving that care.

Dr ROWAN: The second part of that is really improving the indexation of the Medical Benefits Schedule, so reducing those out-of-pocket costs and ideally, for those people who are accessing it, being able to be bulk-billed by those rebates increasing in the amount of money that is allocated federally for those.

Ms Renouf: I definitely agree with that, and I think that is definitely something that should be looked at further as well.

CHAIR: I would like to thank you both for presenting here today. We are on a tight schedule. We have a lot of people we want to talk to today. Thank you very much for your input. It certainly will inform the committee's report and recommendations going forward. We may have additional questions for you after the session which we will forward through for you to answer.

CLAY, Ms Naraja, Board Youth Adviser, headspace National Youth Mental Health Foundation

SPENCER, Ms Rosemary, Clinical Lead, headspace Upper Coomera, Lives Lived Well

THOMPSON, Mr James, Regional Manager, Service Delivery—Allied Health, Open Minds Australia Ltd

TRETHOWAN, Mr Jason, Chief Executive Officer, headspace National Youth Mental Health Foundation

CHAIR: I would now like to welcome representatives from headspace. I would like you to invite you to make a really brief opening statement. If we could keep it down to five minutes then we will have more time for questions.

Mr Trethowan: I will be very brief. I would like to acknowledge the Jagera and Turrbal people as traditional custodians of the land on which we gather today and pay respects to elders past, present and emerging and extend that to all First Nations people joining us today.

You received our submission so I will keep my words very brief. I will just reiterate the importance of early intervention services for young people, particularly when they are experiencing a tough time, and the holistic nature of the services that are required to understand a young person's needs. It is not always just presenting symptoms of anxiety and depression: it may well be in relation to goal setting, around work, study, substance abuse and also general physical health. It is a platform that headspace is very proud to operate across 30 locations in Queensland.

Ms Clay: I am a Kalkadoon and Bwgcolman woman from North Queensland. I am a youth adviser to the headspace board and I chair the headspace National Aboriginal and Torres Strait Islander Advisory Group. We know that young people struggle with higher rates of mental illness more than any other age group. We also know that Aboriginal and Torres Strait Islander young people face significant barriers to seeking help. Young people who are First Nations experience disproportionate challenges in accessing appropriate mental health care. These challenges are a result of many generations of exclusion and the result of ongoing colonisation. These challenges are compounded as the towns, cities and communities we are from are experiencing or fighting to recover from fires, floods and responding to COVID-19.

As national headlines every other day talk of the shadow pandemic facing this country, I worry that our mental healthcare system is not equipped to support young people let alone respond to the needs of more vulnerable groups such as LGBTIQI+, sistergirl and brotherboy, migrant and refugee young people, people with a disability and those who live in regional or remote areas. If a young person works to overcome the stigma associated with seeking help, in the current moment they are likely to face other barriers to access such as wait times and costs, particularly in rural and remote areas across the continent. The mental healthcare system in Australia is often experienced as confusing and not designed with young people in mind. Youth mental health services should be youth focused; designed with young people for young people. We are the experts of our own lives and we want to be actively engaged. It shows that we are trusted and respected and helps us ensure that services remain credible, acceptable, appropriate and responsive.

Mr Thompson: I am a psychologist and the regional manager of allied health for Open Minds. In my role with Open Minds I oversee three headspace centres in Indooroopilly, Redcliffe and Strathpine, and I have worked in varying roles over the last 10 years for headspace. Today I want to talk about some of the challenges, but also opportunities, that we have in headspace in youth mental health.

Over the last 18 months our services have seen an explosion in demand with an increase in complexity of issues and increasing presentations of suicidal ideation, eating disorders and trauma related issues. Unfortunately, this has also coincided with severe challenges around recruitment and retention of mental health clinicians. In short, at a time where we should have been growing to meet demand we have actually been retracting. Young people who present to headspace have diverse needs requiring interventions from brief through to team-based care. Headspace uses a model of stepped care that, when well defined and resourced, can support young people with the right level of care at the right time. However, the issues that our centres and many others face is that they are actually unable to offer the full stepped care model or the number of young people seeking support from the centre are more than we can support. This can lead to young people being offered services that may not necessarily meet their needs.

A key group of young people requiring targeted interventions are those in the missing middle, a term I am sure you have heard many times in this hearing. To support young people in the missing middle, one of our centres has been able to secure additional funding to provide intensive team-based care. This program is showing great outcomes; however, it is only in one location, and that one location cannot keep up with the demand. Considering that by definition the missing middle is not supported by either state or federally funded services, I believe this should be considered a priority in future reforms. Provision of high-quality services for young people and people in the missing middle requires strong state and NGO collaboration. While some headspace centres find collaboration with the HHSs, CYMHS and AOD services challenging, there are examples of strong relationships and localised agreements with state health services. For example, I work with Children's Health Queensland to co-locate CYMHS services at two of our centres. This was a great outcome; however, it took three years of negotiation and only happened because key staff in Children's Health Queensland and our organisation wanted to see it happen. In my view, there is a need to have a more formalised working relationship between headspace centres and state health services so we do not spend three years negotiating a service level agreement to co-locate staff.

Finally, there is a desperate need for more capacity in the system to meet the needs of young people. It has been positive to see the state government's investment in this area, in particular the Student Wellbeing Package, which included funding to increase mental health services in schools; however, in my view it was a missed opportunity to consider leveraging the headspace model and, where appropriate, directly funding headspace to deliver these services in schools. Considering one of the reasons headspace was started was that not all young people want to seek support in schools, a hybrid model of service may have given the best of both worlds. I think systemic collaboration is particularly important given the national shortage of mental health clinicians and that we are all competing for the same limited pool of staff. I would like to pass to Rosemary.

CHAIR: Please keep it brief because we are really running out of time.

Ms Spencer: I might condense mine then. I am a mental health nurse and clinical lead at headspace at Coomera. I am also closely connected with headspace Southport. I have been acting manager across both centres for a few months now. Headspace Southport is a long-established headspace which is known as one of the busiest in the country. Headspace Upper Coomera opened in July 2020 mid pandemic. We are situated in the northern corridor of the Gold Coast, which is one of the fastest growing areas in Queensland. Within three months of opening demand for our service exceeded our capacity. We now sit with a four- to six-month waitlist between initial assessment and the commencement of regular psychological sessions. To manage this we have had to be innovative. We have needed to establish check-in calls and stabilisation pathways to support our young people who are on waitlists presenting with risk. Of course, our waitlists need to be put in perspective. During 2020 and 2021 Queensland headspace centres have supported over 25,000 young people, providing over 100,000 occasions of service. Many parents will also have been supported during these interactions.

I would like to echo the concerns Jamie has raised around difficulties with recruitment and retention of experienced mental health clinicians and the influx of young people at high risk and with complex presentations. Complexity is multilayered and usually underpinned by intergenerational trauma. Family and domestic violence impacts more than 40 per cent of our young people. This week alone we have had two young people from family and domestic violence situations presenting with a recent suicide attempt. Over the last 2½ years the COVID pandemic has placed an even greater strain on our whole healthcare system, and demand for mental health services has significantly increased. During a number of months last year we saw just a complete gridlock of our mental health system. We are unable to step up or down to any other services on our stepped care model. This often means our staff do their best to hold all these clients who have nowhere else to turn, but it means that our staff are sitting with a high level of risk and managing often unsustainable workloads, contributing to burnout and staff turnover.

As Raja pointed out, the mental health system is difficult for young people and their parents to navigate, and there is a real need for greater capacity in our system to meet the needs of our young people with clear referral pathways and supported transitions. Despite all of these pressures we continue to look for innovative ways to improve support for our young people. I believe headspace plays a pivotal role in the health system in connecting young people to the appropriate services. As headspace is so well-known, often we are the first point of call. For all this work to be successful a whole-of-system approach is needed across services and sectors, regardless of whether funding is coming from state or federal government. Initiatives such as our joint regional plan, which on the Gold Coast was coordinated by our federally funded primary health network and our state funded mental

health and hospital service, brought together all of the mental health services in the region to establish a united approach across the region.

Again just echoing Jamie, it took many months for me to establish relationships with our Child and Youth Mental Health Service, but fortunately since January we have been having regular second-weekly meetings with our CYMHS colleagues. It has made an enormous difference in supporting transitions across the sectors when we have needed to do that. It has also improved staff morale—feeling like they can actually do what they are here to do. In these challenging times it is evident that the provision of high-quality services for young people requires strong state and non-government organisation collaboration. The network of headspace services is strategically positioned around the state to play an important role in this collaboration.

CHAIR: I have to admit that prior to this inquiry I had a reasonable degree of ignorance of headspace. There was a service in Stones Corner which came into my electorate in 2017, and about five seconds after the redistribution they moved out. I have not had much engagement. It would have been my perception that, prior to your coming along today and reading your submission, headspace was designed to play that role around dealing with the missing middle—the alternative sort of treatment options for young people who previously had just gone to the GP and maybe been put on a mental health care plan. Where does headspace fit in the spectrum of the continuum of care?

Mr Trethowan: Headspace is a primary care platform. It does fit into that early stage at early age really. Therefore, it is when they are experiencing a tough time. It could be a relationship breakdown; it could be early signs of anxiety, depression, bullying, the impacts of isolation—feelings of loneliness come into play. Some 30 per cent of young people who come to headspace will come once because they got what they needed through one session or were supported to transition to another service. Headspace was not set up to be dealing with the more acute end. We do have the early psychosis programs at Southport and Meadowbrook here in Queensland. Otherwise, what I think the team here has represented is that young people do not have a badge on their head when they walk into headspace; they have a series of things that they would like to talk about—some things immediately and some things later on down the track. Therefore, the supportive transition into other parts of the system are also an important part of our model. That is not just to refer off and hope that they go; it is actually to help them into other services, or we can provide them ourselves depending on the workforce profile, and obviously impacted by regionality as well.

CHAIR: Based on what Jamie said, there is some opportunity for reaching into the missing middle?

Mr Thompson: I definitely think there is. I think that headspace is a very well set up platform to be able to extend on sticking to that age group but being able to extend into areas. The issue that we have always faced is that the funding to do that has been limited. That example of one of our centres, that came out of lobbying and working with our local PHN to go with—

CHAIR: What is that centre?

Mr Thompson: Indooroopilly is the centre that has that particular program. That came out of seeing a need. You would have success with young people who had family members or the financial means to continue paying for support, and they were getting the outcomes they needed. We were looking at it and going, 'It is not okay. Yes, it is great that young people and their families who can afford it can do that, but what about the people who cannot?' They get stuck within a Medicare service model. It is used quite heavily in headspace. It is a combination of both a block funded grant and Medicare delivered services. No doubt, there have been challenges around working under it. It is bulk-billed. Working under a bulk-billed model under Medicare is getting more and more difficult for us.

Where we have seen those positive things in that program is that the red tape went away. We had a team who could just focus on what needs to happen for those young people and not be thinking, 'We need to get them back to the GP to get a new plan,' or young people drop out because they have to do this or jump through certain hoops to be able to get back into the service. When that was removed, that just helped us immensely. I will never forget when one of our staff met one of the young people early in that program and said, 'We will support you for as long as you need,' the young person burst into tears and said, 'No-one has ever said that to me.' That seems so basic, but it is one of the fundamental challenges that we have faced. When we can restructure that, we can do more in those areas.

CHAIR: In terms of distinct Indigenous communities, are there headspaces operating in places like Yarrabah or other distinct Indigenous communities and is there scope and opportunities there?

Ms Clay: Not to my knowledge at the moment. Cairns has a headspace. I guess telehealth would possibly be accessible, but I am not quite sure. I do know that headspace is going through its own transition of becoming, like many other services, an appropriate and safe place for First Nations young people to come to.

Mr MOLHOEK: I think headspace is an absolutely awesome service. I have been blessed to have the Southport service in my patch for a number of years now and I have enjoyed many visits there. The Cairns service is absolutely overwhelmed. I was up there about a year ago and their demand has doubled in a year, and they have staff shortages as well. Jason, I understand the need to support people. I will sound like a bit of a dinosaur in saying this. Almost every submission we get is: 'We need more people, more money, more services. There are more serious challenges.' You could almost be accused of quoting the Premier and saying, 'These are unprecedented times.' How do we address the cause of this? Is the education system failing our kids? Have our societal values shifted so much? Is it just social media? What is causing this tsunami of need in this space?

Mr Trethowan: A couple of years ago we undertook a nationwide survey of young people, and 62 per cent them came back and said that the mental health and wellbeing of young Australians is getting worse. When we asked why, 37 per cent answered with the main reason being the impacts of social media. Secondly, it was around expectation of parents and expectation of others. It is unprecedented times, but it was also hard before the pandemic. There are the impacts of: natural disasters, climate change, growing up in a global society with the lens through an online world about comparing to others, and the body image related matters that come from overconsumption of social media. It is not to say social media is a bad thing. We would not say they should get off social media altogether; it is just about moderating your use. As the team would say, family dynamics—financial distress, family arguments, family separations et cetera—can all play a role. The impacts of homelessness and not having a sustainable housing environment play a role. There are all these well-known determinants. What we find ourselves being is the first place for young people to come and have a chat, but it is not all about, 'We need more clinicians; we need more of this everywhere.'

A big part of headspace's role is to reduce the barrier of stigma in terms of it being a reason to come forward and also, increasingly, to support the valuable role of parents, carers and broader families in their understanding of how to pick up on warning signs, how to have safe conversations, how to talk about suicide, how to talk about suicidality, how to understand anxiety and depression and how not to judge but to listen. It is very easy for older people to have the answers. We have to have our young people go through the journey themselves. I think that is a community capacity role. That is why we use sporting clubs and schools as a platform for socialising, but then if you reduce the stigma and 'I want to talk about it to someone in a professional sense' we owe it to young people to be present when they come forward to see us.

Mr MOLHOEK: That study you referred to—

Mr Trethowan: We can provide that, yes.

Mr MOLHOEK: Can we perhaps have that as a question on notice?

CHAIR: Sure. If you could provide that, that would be great.

Ms KING: I noted with interest your comments, Jamie, about the headspace model contracting at exactly the time it is meant to be growing. I know that headspace had a shopfront in my electorate on Bribie Island for a period of time. There was some attempt to collaborate with the local high school, and then I was told that a management change led to a change of focus. What we are hearing about over and over throughout this committee hearing process are the extraordinary pressures on workforce. I wanted to ask for further comments from you on that, particularly around whether other professionals could step into your model to provide assistance and whether headspace uses peer workers, especially young people as peer workers, and whether that could be enhanced to provide more places for young people to land when they come through the door and need that immediately—six and 12-month waiting lists are not a good solution for our young people.

Mr Thompson: No. Jason is going to talk about one part of that. One of the first things I would see, as I describe it, as a top-of-the-cliff issue that I think could get worse is access into the professional streams. For example, I am a psychologist. I was registered through the 4+2 stream—a stream that is now not available anymore to seek registration. Now leading towards only access through a university masters level to get trained, I suspect if there are a lot more spaces open for that there would not be an issue. It could be that you see some challenges around how people can get registered. I do believe there are other professions that would be able to support these services. Again for us, where we have been somewhat restricted is in terms of what services we can deliver, which professions can deliver under Medicare when they are a Medicare delivered service. We have

more flexibility when it comes to the people who are delivering services under our core grant. The short answer is yes, there are a number of opportunities. We are looking at exploring some opportunities as well and looking at what new models there might be to be able to support young people through, whether it is briefer interventions with different professions or something else. I think there is an opportunity there with peer support which is what Jason was going to talk about.

Ms Spencer: The peer community lived experience support workforce is incredibly important in our model. They really make a difference assisting our clinical team. We are very lucky on the Gold Coast that we do have trained clinicians, but I know that in regional and remote areas they do not. We had to look at other sectors of the workforce and train them up to doing intake roles and things like that, but our peers will run groups or co-facilitate, engage with the community and with the schools. They are enormously important. It is about having a well-rounded workforce. We are not just clinical. We have focused on that a bit today.

We have tried to have different streams. It is trying to really work out what that young person needs and wants and maybe move a little bit away from this traditional model of an intake assessment on to a waitlist. We have to look at different streams. As Jason said, there are some people who just want the help right now in their situational crisis. They do not actually want 10 sessions. They still may have lots of trauma but they do not want to do that long-term work now. That is fine. We really want to be there to meet their needs. When we have young people who are ready to work on their trauma, which is a longer term prospect, we want to be able to provide that too.

We are constantly rethinking how do we best service our young people, how do we be flexible to hear what they need right now? It gets complicated because sometimes young people do not even want to be there. It is the parent who wants them there. When you are working with minors, there is lots of complexity around issues with confidentiality and privacy, and we have to work with all that. There is great opportunity to use our peer and lived experience workforce.

Ms KING: Are they young people?

Ms Spencer: Yes. We have our youth advisory councils and we have young people. You are probably aware that the peer model has changed a bit to a paid model. We used to have a volunteer model. I think you have people coming who will explain all of that to you in some of the other sessions. The peer space has changed a lot. We cannot just use these people as volunteers and not recognise the expertise they are bringing. We need to pay them. In headspace, and I know at Gold Coast University Hospital as well, they are really trying to utilise peers. They are a valuable resource.

Dr ROWAN: Thank you to the panellists from headspace and all the other organisations that you represent and work in and thank you for all the work that you do. I want to come to Jamie around that model and all of that great collaborative work with Children's Health Queensland in getting those child and youth mental health services co-located with headspace. How do you replicate that or who should lead that? That collaboration and coordination has achieved some optimal outcomes as far as service alignment and coordination is concerned. Who should lead that when you are trying to look at that in other areas? Is that up to headspace or the hospital and health services or the primary health networks? How do you, for want of a better word, 'systematise' it so that it is not a random chance that those great conversations and outcomes occur when you get alignment of different service providers to provide care for people who need it?

Mr Thompson: The one area that I think it should not have to fall to is the individual local centres, because it is really hard work when you are also on top of that trying to run the services day to day. You work on it for a while and then you have to step away from it. You have to keep doing that. The reality is that, when I said three years, in our sector in some places you could have had three people change their roles in that time as well. It is a hard question to answer, but I do think it has to start at some sort of much higher level—probably state—and then maybe the PHNs. There is a theory that we all work together—and we do. I do not want to dismiss that we do, but it still keeps coming down to what either Children's Health Queensland or the local HHS can do. What do they have on the ground? They are just as stretched as we are and getting stretched even further.

The gap for us is challenging with kids, but it is a lot better than for 18 and above. The space we have to try to navigate for them has become cavernous. A person under 18 may have got into a CYMHS but then a person over 18 is so far away from being able to get into a state service. They end up cycling back to services like ours because they are just not even close to the threshold—again, given the pressures for them—of state services.

The short answer is that there would need to be an agreement—whether it is through the PHNs. In Queensland I would see a place for the Queensland Mental Health Commission as well to be involved in how that becomes practically implemented. The upside of it is that we put three years of work into getting one centre up. The second one went up just like that because everything was worked

out and all we had to do was an amendment for a new location. The hard work was done and then it got much easier to build on that.

Mr Trethowan: There are a number of areas where there is a strong willingness on the ground from state services and headspace services to partner and collaborate. When they are stretched and stressed the collaboration becomes more complicated. Where state governments write in expectations around integrating with headspace and linking in—and in some cases investing in headspace, having state funded services operate out of the building of headspace as a part of the operating model—it does go really well. It does make a difference between whether things happen as an optional relationship-based approach and whether things happen in a more systemic way where the expectation is that over time you will work towards that.

Mrs McMAHON: Jamie, I just want to go over something you touched on in relation to the work that has been done in schools through not only the GPs in Schools but also wellness professionals going into schools. I have heard there have been some collaborations between headspace and schools. Is there potential—particularly in our more regional areas where you might not have the infrastructure to build the designated headspace zones but also where there are competing workforce issues—to collaborate between the state funded programs being delivered in high schools and the headspace model and have a co-delivery model in schools? You did mention some barriers about kids perhaps not wanting to access those services in schools. I understand there is stigma and all of sorts of things around that. Rather than having competing workforces—headspace, education and then wellness—is there an opportunity where we can use infrastructure that is already in place and have a combined workforce that is working with that same cohort of kids?

Mr Thompson: My view is, yes, there would be. One of the roles I had with headspace was working in headspace school support for a period of time which is a suicide postvention service. A huge amount of work we did with schools was that from a mental health perspective you need a systemic approach to what you are doing. One of the people speaking before us talked about this. What happens is that lots of good little programs go in. They are good but they are not sustained or they are not embedded into everything that is done.

Talking from a personal perspective, I have two young children who are in primary school. What I see in schools these days is so far from where it was when I went to school. It is frankly amazing when a primary school student talks to you about depression and anxiety. When I was in primary school there was not a chance I knew about that. I think there have been huge shifts made.

To the point that I was making before, that is not to say that lots of young people do not start with school being the place they might initially seek support. It might be that for some of them it is not a school location where they want to continue to have that support. That is where I think it is a great gateway with the opportunity to continue being supported at school or seek somewhere where you are not going from one person here who you know to some other person who now you do not know out of the school. That is where that dual opportunity would work really well.

Mrs McMAHON: Raja as someone who is closer than us to the demographic that headspace deals with. Whether school kids are primary school or high school, I understand headspace has an age limitation. Is the ability to access safe places or wellness places during school hours something that really can make a difference for a young person to make that first reach out? It might be the first and only or it might be the start of their journey on getting better. What are the school environments like now where a child might feel comfortable coming into a comfortable space designated within a school?

Ms Clay: For me, when I started to experience mental ill health, the first person I spoke to was actually the school guidance counsellor. I would spend regular time with this person going through different things. I think it is helpful to have someone in the school space that you can definitely go to. The school that I was at when I finished high school had a school psychologist. That was someone who was essentially an advocate for me and would have the conversations with teachers and the other people who needed to be kept up to date with how I was going.

It is important to have a safe space. I do not know if it necessarily needs to be a GP in a school. I do not know if it necessarily needs to be a clinician. I think it is about having someone who can provide and create that safe space for a young person who is experiencing any kind of distress to go and talk to but also having someone who can advocate for that young person to their teachers and principal around assessments and exams and things like that.

Ms KING: Raja, I had a question for you as well. We have received submissions and evidence during this process in favour of a change to the categorisation of youth mental health to be from, say, 10 up to 25. Jamie was talking about the gap after 18 where you are not acute enough to be admitted into a hospital-based state service and so you cycle back to headspace. Do you have any commentary on what is the appropriate age range to be considered for youth mental health and what the benefits of a change would be?

Ms Clay: I think we could always expand on the age for young people. We do know that children's brains are still developing up until they are 25. That is maybe a good cut-off age. Even in my personal experience, I was with state funded child youth mental health for a while. When I turned 18 there was no-one. I was not acute enough at the time to access adult services. Sorry, I have lost my train of thought. Could you ask the question again?

Ms KING: I think you have probably answered it, to be honest. You talked about the gap after you turn 18 and suddenly your services are not funded. Do you have any comments about what mental health services need to do and be to be more culturally competent? You talked about headspace being on its journey. Do you have anything that you would like to add to that? It is a big question.

Ms Clay: Yes. I think ensuring that First Nations people—it is the broad spectrum. Instead of having one identified role within an advisory group, it is having multiple. It is having a men's identified role, a woman's identified role, gender diverse identified roles, young people's roles, elders' roles. It is about having the humility to sit there as an organisation or a service and understand that there is still a way to go. To create actual change for First Nations young people there needs to be—I cannot think of a better word for it—a truth-telling process and then to implement the recommendations that come out of that. I am trying to think of a general example. It has skipped my mind.

Mr O'ROURKE: In your submission you talk about communities in rural and remote Queensland often having no services to provide prevention or early intervention. Then you go on to talk about the fact that headspace is in a unique position around young people to address some of that need in those rural and remote communities. Could you expand on how that could be done?

Mr Trethowan: Four in 10 of the headspace services in Queensland are in rural and regional communities. Increasingly, that number is going up in terms of the numbers of new ones. When we go into a rural community there might be a GP service, which is incredibly valuable, and other supports that may be in the community, but young people's understanding of headspace and the brand and what it brings is quite strong. We have not spoken a lot about the online offerings. There have been four million hits on the website. We see many young people having web chats in the evening with mental health clinicians, so there are plenty of opportunities to offer services to rural communities.

When we open up services, what we find is that many young people coming forward are coming forward with a long history of need and a high degree of complex needs which arguably and ideally would have been seen to maybe a few years earlier. That is okay because they are coming forward. I find that in rural communities headspace flourishes because it is a youth platform. It is a time for agencies, local governments and others to come together in the best interests of young people.

What keeps it honest and what keeps it focused is having young people at its core advising every headspace centre in rural communities. If it were left to us, it would fail. If it is left to young people and with our guidance and response, it works and it works really well, particularly in rural communities because there is safety in coming forward. The shame and stigma associated with mental ill health is very real and more prominent in regional communities.

As I said before, it is about community capacity building, linking up with sporting clubs and other places where young people are, and understanding our priority groups such as LGBTIQ+—29 per cent of young people who come to headspace in Queensland identify in that community. There is a degree of safety for that. It does not mean it is easy. We need that skilled workforce and also appropriate linkages to state services which is obviously a challenge. As I said earlier, everyone is working with the best intent on the ground to make that work for young people when they present.

CHAIR: Thank you for your presentation. We are on a tight time schedule today. The presentation you have made today will certainly inform the committee's report and recommendations going forward. Thank you very much for the work that you all do in the sector every day. There was a question taken on notice. We will need a response by the close of business on Friday, 18 March.

ARRO, Ms Paula, Chairperson, Peer Participation in Mental Health Services Network

GRECO, Professor Michael, Chief Executive Officer and Founder, Care Opinion Australia

KISSANE, Ms Viv, Chief Executive Officer, Peach Tree Perinatal Wellness, Peer Participation in Mental Health Services Network

PENTLAND, Ms Tina, Carer/Family Member Representative, Peer Participation in Mental Health Services Network

REID, Ms Alicia, Patient Experience Lead, Operations Manager, Care Opinion Australia

SOMERVILLE, Ms Rebecca, Client Liaison Officer, Care Opinion Australia

CHAIR: I would like to welcome representatives from the Peer Participation in Mental Health Services Network and Care Opinion Australia. Thank you all for coming along. I ask each organisation to make a very brief opening statement. We have read your submissions so we do not need you to repeat your submissions. If you could just give us the key points of what you want to say to the committee, that would be great and then we can go to questions from the committee.

Ms Arro: Firstly, I would like to acknowledge the traditional owners of the land on which we meet today and pay my respects to the Jagera and Turrbal people. I also pay my respects to people with lived experience and those families and carers who advocate on our behalf. My two colleagues here are Tina Pentland, who will speak briefly from a consumer and carer perspective, and Viv Kissane, who will speak around peer workforce and lived experience workforce.

I would like to say that, as MPs, you would appreciate and understand the importance of listening to the voice of your local community. Likewise, the mental health system needs to be doing the same and needs to be led by people with a lived experience. When we talk about recovery, there is clinical recovery—maybe getting through the K10—but the personal recovery is really what we are talking about here.

You have read our submission so I will not go into that too much. PPIMS has existed for six years. We have a membership of over 300 people who have a lived experience as a consumer, carer, peer worker, educator or trainer, or work in the mental health system and also have a lived experience. We meet regularly, we undertake capacity building and, most importantly, we co-design. We have all watched a lot of the hearings and read the submissions, and you would have heard the 'C' word, co-design, being floated around. We see it written in numerous documents—co-design with key stakeholders, consumers and carers. We would like to have some discussion today about what co-design really means to make sure we are operating from a clear understanding when we use that term.

One of the key issues for us at the moment is the fact that we have not had a collective voice and an independent consumer peak now since 2017. Yes, we know that Queensland Health have undertaken consultations in 2018-19, but we are in 2022 and we only now just have a newly established peak body which is still not actually functioning. There are no membership arrangements and we are not sure how to engage with them. Our PPIMS network actively reached out to the interim CEO and said, 'Please come and talk to us. We've got so much to share.'

The other key point I would like to make—and I am referencing research here by Dr Louise Byrne—is there is an extensive evidence base now about the important role of people with a lived experience being partners in design, implementation and development. In fact, a comprehensive piece of research was released on 11 January 2022 around community based social interventions for people with a lived experience with severe mental illness. They looked at 72 papers. It was published in *World Psychiatry.* They found that traditional social interventions do show evidence of cognitive impairment but these are not translating into real-life change for people. What they do say, however, is that there is an emerging evidence base for peer-led, peer-run services. I have so much to say—

CHAIR: We might pull you up there and go to the other organisation because we really want to ask a lot of questions. That is the best way for us to get information. Can we have a brief opening statement from Care Opinion Australia?

Prof. Greco: Our submission was around amplifying the consumer voice in mental health. I will tell you a bit about us. Care Opinion Australia is a not-for-profit, independent, transparent online consumer feedback platform. We are about making it simple and safe for consumers to tell their story

about their experience of care in a way that helps organisations listen, respond and make changes where necessary. This month we are celebrating our 10-year anniversary in Australia. We are rather unique in Australia and have now been adopted by a few governments. The Western Australian health department now use us right across their public health system. The Victorian health department are piloting a program across 35 per cent of their health services across the state. Because of our emphasis on transparency, NSW Health are now looking at an extension of Care Opinion across their state. At this stage, it is only Sydney services that are involved.

We would argue that consumer feedback in the mental health sector is not done well, or at least it is missing its potential. Currently, consumer feedback has a measurement paradigm or is focused on complaints and compliments. This is really only half the story. It is a good part of the story, but it is only half of the story. What is needed is a relational approach, not just a measurement approach, to feedback where consumers—and by 'consumers' I mean patients, clients, carers, family, friends, advocates et cetera—can independently, publicly, anonymously, safely and constructively post their experiences of care in such a way that they can see who is listening, who is responding and who is doing something about these things when things go wrong in near real time.

We know that the very process of telling their story can be quite therapeutic for consumers. This therapeutic impact is enhanced when they can see staff reading their story and staff responding to their story and making improvements where necessary—all pretty much in near real time. It is not just consumers who benefit from a narrative-based feedback platform; research is now showing that staff benefit from hearing consumer stories in near real time. It is reminding staff of their purpose—of why they come to work. In addition, research is showing that their capabilities improve and the sense of gratitude that they experience from these stories helps boost their morale. In other words, the evidence is showing a cultural change across care services when they engage consumer feedback in this way, a relational way, not just a measurement way.

We do have a quantum of mental health stories in Queensland. However, because there is no current commitment to a statewide approach, it is rather ad hoc with very few responses to stories being posted back from services to those with mental health issues, unlike other states that are now engaging. That is all I would like to say at this time.

CHAIR: The name of your organisation—Peer Participation in Mental Health Services Network—suggests to me that you are looking beyond just paid positions; it is a broader remit. I sensed from your submission that there was a real frustration with the mental health branch in Queensland Health. It seems to me that, everywhere we have visited and the people we have engaged with, there are a lot of people employed who have lived experience and there seems to be developing scopes of practice, practice standards, even training. What is it that your organisation is looking for in terms of involvement and participation for people with mental health in service delivery and development?

Ms Arro: I think the point is that there is a tendency for that tokenistic 'Let's get a consumer and a carer to sit around the table with 20 service providers and that way we've engaged.' We know that there are frontline peer workers in the industry. What we are needing to see is high-level positions, like what has resulted from the royal commission in Victoria—for example, having a person with a lived experience involved in this committee and its deliberations; having lived experience educators and trainers; having lived experience academics; having people with a lived experience sitting on tender assessment panels when contracts and new services are going to be commissioned. Viv manages Peach Tree and she might be able to speak about this too.

Ms Kissane: I have been a member of PPIMS since it began in 2016, but my day job is that I am the founding CEO of Peach Tree Perinatal Wellness, which is a peer-led, peer-run perinatal and infant mental health service that is based in the community. We operate across three parent wellbeing centres in Brisbane. We currently have about nine FTEs, which is shared between 21 lived experience workers. We have that throughout all levels of our organisation—from volunteers, peer support workers, program managers, team leaders, mentors, supervisors, right through to our Board of Management. It feeds throughout the entire organisation. Everything that we do comes from the core and the heart of lived experience, and I think that is a good way to make sure that we are able to listen, respond and adapt quickly to our community and their needs.

Ms Arro: I have one other point. There are now national guidelines for the lived experience workforce. In Queensland we worked with the commission to develop a Queensland framework for the lived experience workforce, which was launched in 2019. What we are seeing is investment in writing these documents, but we are not seeing the investment into actually implementing them.

CHAIR: My question is for Care Opinion Australia. I think every MP would feel as though they are a part of the complaints system for the health system and every other government service. I have certainly had some experience internally in hospitals, particularly in health services more broadly. All systems have systems of feedback. There are patient liaison officers, there are systems for dealing with complaints, there are ongoing quality improvement systems and externally to hospitals we have OHOs, Ahpra and even capacity for civil and criminal actions by people. What does your organisation suggest could be brought to the table that could improve on what already exists?

Prof. Greco: I think, in short, it is a relational way of engaging with consumers in a public way. Consumers can see who is listening and responding to their stories, and they can post anonymously. It is another channel, but it is a very different channel.

There are generally three areas of consumer feedback: there is complaints and compliments; there is measurement paradigm, which is around, 'Let's measure. Let's survey. Let's do patient reported outcomes measures and patient reported experience measures.' What is missing is more of a relational or dialogical or two-way approach. We want to move from a data-centric model. I get the data-centric—that is my background in medical education—and it is really important, but it is missing transparency and that immediacy. I will let Alicia comment.

Ms Reid: I would also say that in working with our subscribers or our services as they would be for all of you, our platform provides the opportunity for people to share their stories, whether they are 100 per cent positive or quite critical of the service and everything in between, whereas a complaints system gears people in that mindset of complaint. Compliments: people send cards and things like that. Our system allows for a story to have positive and negative elements, all within the same feedback stream, which can be polarised so the service can see what they are doing really well and where there are areas for improvement. That can all reside within the same story and not all in the clinical space necessarily either. It picks up those people, process and place elements of the patient experience as well.

Mr MOLHOEK: In your submission, Paula, on page 7, you talk about lived experience workforce development, and you flag an issue of concern—I might be misreading it—where you talk about the NDIS pool of workers attracting people with unacknowledged mental unwellness looking for an easy job, without qualifications. Is that an issue of concern that you are flagging, or are you saying that there simply needs to be greater support for people with lived experience that work in the NDIS sector?

Ms Pentland: I wrote most of this submission because we were flat out at the time, and I take responsibility for having included this which was a quote from one of the PPIMS network members and her personal experience of having a peer worker work with her through the NDIS. She said very clearly that, in fact, she ended up counselling the counsellor. I included this quote here just to illustrate the disparity and the poor understanding of the importance of supporting peer workers and regarding them as an integral part of the mental health workforce, as much as anyone else, and that they need to be supported with appropriate training and mentorship in order to do the job they have been asked to do. Clearly this illustrates an example of where they were not supported and could not do the job. I had the appendix to our submission, which was written by another of our PPIMS members where he talks very clearly about how he struggled as a peer worker because he was not getting the support he needed, particularly in the HHS.

Ms Kissane: To add to that, the National Mental Health Commission guidelines that were released at the end of 2021 were an incredible milestone in the professionalisation of our workforce, but it is largely still a lived experience workforce. We are unregulated. There are no standards of practice. There is no accountability as such. I guess that is where the concern comes in with recovery coaches and, indeed, anyone working in the lived experience, and also workplaces acknowledging and valuing and understanding the lived experience workers who are coming in and their workplace readiness in terms of the support structures which are required around this very unique workforce.

Dr ROWAN: My question is to Associate Professor Greco. As you mentioned in your testimony before, talking about amplifying the consumer voice to help organisations to listen and respond, when I was an executive director of medical services in Uniting Care Health, I certainly saw an organisation utilising that to move from what I would term a transactional complaints and compliments way of interacting with consumers and patients to that relationship approach, that sort of cultural change, and that critical feedback loop that you talked about that not only helps consumers and patients but also clinicians to grow and understand their purpose there. My question is: given the benefits of those models and what we are talking about, how can Queensland Health implement a statewide approach, regardless of the systems that they use, that can be driven to move from that transactional approach of compliments and complaints to that relationship approach? What are the systems that are needed or the mechanism or the approach to have a system adopted across the state?

Prof. Greco: It picks up on the chair's question as well. Thanks for summarising that. I should get you up here to talk about Care Opinion. I have been in this area for a long time. I was the national patient experience director for the NHS in England for four years, under Tony Blair back then, and whilst I am a big fan of measurement based feedback—and this has been going on in the UK now; Scotland, Northern Ireland and England have adopted it and Wales will come on board soon—I have never seen a system in terms of feedback where consumers really feel heard. It is also to do with where it starts. You mentioned culture. Often feedback goes to a department within a hospital, but this is about giving feedback to everybody in the system. It is just an email alert. You do not have to do anything; you just read it. It starts to change the culture when you hear it. Some 70 per cent of our stories are purely positive. It is a myth that people think they are going to be inundated with negative stories. That does not happen. We have been going 10 years.

In other states, it is a simple process and not an expensive system; we do have the platform. It is a commitment by the executive to say, 'We believe in transparency.' Because it is web based, it is a URL; they can put it on all of their discharge letters. These are the experts that are sitting to my right who have to make it happen. Would you say that? Do you want to add to that?

Ms Reid: I would. As you say, there are systems that sometimes almost get in the way of this work from occurring as it should. Where we see the platform at its most successful is on the shoulders of very dedicated individuals a lot of the time, being there to provide those engagement links and connections for folk around what we are actually part of. There is a bravery and a commitment there to receive the good, the bad and everything in between, and to respond with compassion to clients about the service and express disappointment when it does not go the way that it should.

From a systems point of view, I think some of that is about what was mentioned earlier in the opening comments around compliments and complaints that mainly it is complaints thinking. It is thinking more about feedback and thinking more about the quality and safety aspects of the conversation, not just looking at the complaints that we would hope to sweep away under the rug as quickly as possible and only deal with the ones that we really have to. We see it like a sandwich, where the executive come on board and are incredibly committed and articulate that through policy, supported by those at the coalface working with patients on a daily basis, and their volunteer workforce to sandwich that up for something quite successful.

Prof. Greco: In one of the states, a few of the health services people who had an expression of interest were very keen and then it became statewide. They could see that the sky had not fallen down around transparency and around public stories, but, yes, you needed those willing folk initially, like any change.

Mrs McMAHON: My question is for the PPIMS. I have an interest in the training packages that are available. I worked in vocational training for a period of time. Before I ask my question, I want to touch on something you mentioned before about people identifying themselves as having lived experience and how important it is for those people to make up and be representative of a range of organisations and hold senior positions in every part of society. How important is it, given the stigma that is still really attached to mental health, for someone to just publicly stick their hand out and go, 'By the way, I have lived experience,' but without going through what can potentially often be, despite the level of recovery, a traumatic thing in itself?

Ms Arro: I am so glad you asked that question. You have hit one of the key points there—the stigma and discrimination. I will speak to two things: firstly, the vocational and education training system. We have had a Certificate IV in Mental Health Peer Work developed since 2014. What we have seen, though, is the requirement for peer workers to have lived experience in order to deliver the qualification. Here in Queensland, as you would know, it is regulated and checked—

Mrs McMAHON: RTOs and everything?

Ms Arro: Yes, RTOs. We only have a handful of RTOs who deliver it. PPIMS has funded three years of scholarships and tried a few different RTOs, and the accessibility and quality has not been good at all because there has not been that wraparound support for people who are potentially vulnerable, may not have studied.

The second point I really want to make is around stigma and discrimination. PPIMS now works at a national level with all PHNs and speakers lopped with rural/regional. In small country towns, you do not want to be known as the crazy one, so it is very difficult to recruit—I hope I did not offend anyone with that. I use the term 'crazy' for myself. At rural/regional levels, to be able to get that direct voice, advice and expertise is challenging unless there is lots of support around that.

Stigma and discrimination has been part of the fifth national mental health strategy. There is now a national stigma and discrimination strategy rolling out. If you look at the research, organisations that employ and engage people with a lived experience—I want to qualify, peer workers with mental health and recovery. It is not just, 'I have mental health issues; I can be a peer worker.'

The more organisations have exposure to seeing people like us who have quite significant mental health issues, suicidality and all of that, and how we can function and we can provide expertise, the better. It is a big risk. I have been working in Queensland for about 30 years. I fronted up six years ago for an interview where I knew most of the people on the panel and I had to disclose. I thought, 'I am over 50; I do not really care now.' I hope I have answered your question.

Mrs McMAHON: Given the statistics we have of how many people in Queensland have experienced a mental health issue, we do have to assume that the vast percentage of those are in some level of recovery and that there are far more people out there with lived experience who are not talking about it. How do we normalise that?

Ms Pentland: I just wanted to add that, as a carer with lived experience with mental ill health, the PPIMS network has the important function of bringing people with lived experience together so that everyone is at the same table. We have basically obliterated stigma in that network so we are, if you like, a role model for how it can be. I forget that there is stigma out there because of how it has been in my experience. I know from when my son became ill how everyone disappeared. You lose friends. You lose everything, actually, because you are on your own. The fact that something like this network exists is actually a beginning for people to get back the pieces they have lost.

Mrs McMAHON: Do you have any specific feedback on some of the training aspects? I am happy to listen to quite scathing aspects of the training as well.

Ms Kissane: I firstly just wanted to touch on your comment about how prevalent mental illness experiences are in our community now. Probably most of us in this room do have that as an experience. When you talk about workforce, I am referencing the work of Dr Louise Byrne as well in terms of identifying non-identified roles and that there is a difference. I know there are lots of health professionals out there who have lived experience but they are not wearing that on their sleeve when they walk into the workplace, and that feeds into the stigma and discrimination parts of it. I think historically we know there have been incidents where lived experience peer support workers have been put into workplaces and have not had the correct training, professional development opportunities, exposure to leadership and mentorship and communities of practice, and they have basically burned out and failed because we get pushed outside of our scope of practice, we burn out and those sorts of things. If we take that back to training, I think it is critical because being a lived experience worker is a skill set. It is not just having lived experience: there are a whole range of different types of skills that are also needed to safely and effectively do peer practice.

It is great the certificate IV has been developed. I think, as Paula mentioned, there are significant concerns around its delivery. It is the expectations of people and the level of support that they need while they are completing the qualification, as in not having the support. As part of the certificate IV they need 80 hours of community or clinical placement, and finding those places is very difficult. I want to acknowledge that the HHS is doing some work around being able to accept students to complete those hours, but for my own organisation those students walking into my workplace need a lot of extra support, and I think there needs to be some incentive for workplaces to accept students for placements but also incentives to embrace lived experience within the service delivery models, because it is hard work. It is extra effort. It is extra investment that is needed around this workforce, but without those this workforce is set up to fail.

CHAIR: I want to follow on from a question from Dr Rowan. I think I may have worked at St Andrews when that system was in place. How do we make these systems become more than just another box that a nurse or allied health professional has to tick? I think we had those things that we had to get the patients to push, and we never understood what they were doing or why we were doing it. We were just told to do it. How do we get those systems embedded into people's practice? Because my argument would be that most nurses, doctors and allied health professionals as part of their rapport with patients are always seeking feedback and always looking to improve practice, but that ends the moment your care finishes, and that is often the difficult part for getting that feedback into your practice if complaints or concerns are raised afterwards. How do we move to that?

Prof. Greco: I think you have to—and this is what the system does—allow consumers to feed back when they want to feed back so they do not just get presented with something as they are leaving. It is just a URL address. It is www.careopinion.org.au. They would go on in their time and tell

their story of their experience. One of the benefits of Care Opinion is it can cross services. They are telling a story so they are not being boxed in on how they provide feedback. I might ask Bec to comment on that.

Ms Somerville: What we find is it is most successful in engaging your clinicians at that coalface level to give them access to read the stories, whether they are receiving the alerts or whether those stories are being brought into your safety huddles, into your quality meetings, and so this is where we need to not just have your clinicians asking for the feedback—although those conversations are important to have—but sharing with them what the feedback says and what that means to them. When it is positive, we want to see clinicians being commended for that and bringing that staff morale up. But also, in terms of improvements, getting them involved in the response process as well so they have to think through what did happen. We encourage people not to be looking at the specific experience but to look for the processes behind the experience and where it could have gone wrong. COVID has been a fine example of that, where you have things maybe going well in the clinical space but in terms of that front point of view when you are going through your security checks and your administration, your reception, that communication where systems are under pressure, trying to cope with that. That is where we encourage. We find that it does work very well in terms of being engaged with that process rather than it being a tick box, because it becomes part of their experience and part of their role as well.

CHAIR: I would be interested in terms of how we get a two-way dialogue going, because from a clinician's perspective—and maybe the member for Moggill had the same experience—often you feel like these days as health professionals you are often just being told constantly you are wrong and that you are doing everything wrong. That has been heightened, I think, over the last two years. We have seen people at really high levels who have very strong opinions about things they have absolutely no idea about and no evidence to support suggest to health professionals they are wrong. How do we get that two-way dialogue going?

Ms Somerville: I think part of this is again the assumption that the feedback is often saying they are wrong, because it is often not saying they are wrong but rather saying, 'You're doing something right.' I think an equal part of this process is to have the mechanism to be told, 'You're doing the right thing' and the impact you have had on that situation. This is also where the moderation of the stories comes through. That is quite a detailed process when we look at that. It is not just around protecting the anonymity of the consumer and the staff member; it is always put in the context that it is an opinion. It is perhaps a situation that happened as to what their understanding was of the clinical space, and having that dialogue allows the services to come back in and put some factual information around that. For example, we had a story about the fact that somebody's desperately needed organ transplant was denied because they were not vaccinated. The service was able to come back and say, 'Actually, that's not the case,' explain what the process is around transplants in terms of vaccinations, put some facts in, but also surround that with compassion and understanding and listening. That is where that process really comes to the fore.

CHAIR: In those states where you have rolled it out—it sounds like it is pretty advanced in Western Australia—is there some kind of engagement at every part of the organisation? Because you can come and tell me there is a problem or there is something that could be improved, but if I have no control over it I can listen to the story all day long but I cannot do anything about it.

Prof. Greco: Yes, but everybody has read it there. That story has been read 400 or 500 times by the public, but also responses might come from where the point of care happened, and then another response will come maybe the next day or the same day from the executive and maybe from the chief executive. So the storyteller, whether it be the carer, consumer, whatever, they are seeing these responses. They are public. Once you have something public, things move quite quickly to resolve the issue.

CHAIR: PPIMS, you have the best acronym going. Well done, I think we are all impressed with that. There is another group coming to present later on, Mental Health Lived Experience Peak Queensland. You raised a number of times in your submission your frustrations around the lack of representation. What are your views on this organisation? Is it too early to tell? You clearly have tried to engage. In terms of what you understand of the organisation, is it heading in the direction that you think needs to occur in Queensland?

Ms Arro: I will just speak to the facts. In 2017 there was no peak; in 2022 there is still no operational peak. It is not laying blame on the current interim CEO. We want to support him as much as we can. It has been a two-year development to get the organisation up and running. I do not understand that. Queensland back in 2012 in the mental health branch used to have a consumer and carer branch. We did have an active peak body and were leading the way compared to other states

and territories. Because I also work nationally, I hear from other states and territories about some amazing collaborations that are going on. When we talk about workforce, for example, in New South Wales the peak body, the ministry for health, the PHNs and the commission are all co-contributing and collaborating to deliver lived experience workforce development in rural and regional areas. We are not seeing that up here. We do not have that peak up here. We do not have a deputy lived experience commissioner within our Queensland Mental Health Commission. Those are some of the things that ideally would be in place. Yes, there is frustration.

Dr ROWAN: Just to clarify, did that exist beforehand in the mental health branch and now it has gone?

Ms Arro: Yes.

Dr ROWAN: So it did exist. Do you know why?

Ms Arro: Change of government.

Dr ROWAN: Ideally with those references to other state jurisdictions should it be within the mental health branch or within the Queensland Mental Health Commission?

Ms Arro: The research is telling us that we need lived experience at the executive level. The National Mental Health Commission has recently appointed a director of lived experience. In Victoria, as a result of the royal commission, the Victorian health branch now has a very high level lived experience position. The New South Wales Mental Health Commission has deputy lived experience commissioners. We do not have those positions here in Queensland and we do not have an independent functioning peak body.

Dr ROWAN: So we need that in the Queensland Mental Health Commission and in the mental health branch within Queensland Health?

Ms Arro: And an independent body that can genuinely represent people without the fear of losing funding and those sorts of things.

Ms Pentland: The point is that there seems to be such a core understanding across all levels. I am just appealing for anyone who has the power to make a difference to understand the importance of lived experience engagement and how it is healing and promotes recovery. Paula mentioned some evidence at the beginning about this. We need recognition for that so people are confident they can act and that they are spending money and time where it is going to make a difference.

Ms Arro: There is one other thing I would just quickly like to add. I really do not want it to be perceived as an us-and-them situation. Over the last five-year period we appreciate the value of allies. I do not know if they have spoken with you yet or whether they are on today, but the Queensland Alliance for Mental Health has really stepped up to support us because they are a peak body for the mental health service sector. Allies are also very important, this committee is incredibly important, people within the HHS who really genuinely value, and organisations that have a culture understanding of the value of authentic engagement with people with lived experience.

CHAIR: I have one final question to Care Opinion Australia. Obviously a lot of my questioning has been around hospitals, but I assume you operate in a much broader context wherever community services or health services are delivered potentially?

Prof. Greco: Yes, more so in hospitals at the moment. There is no reason why it cannot be around the community hub. I think Lives Lived Well is engaged, and I see that someone from there is speaking today. They are engaged with the platform. We have sort of gone for the low-hanging fruit in one sense to get systems involved, but we are growing. In the UK our sister organisation Care Opinion is very involved in the mental health space. They have two mental health officers. People like to tell stories about their experience. It is quite therapeutic.

Ms Reid: The partnering with consumer standards that hospitals are working with most closely is why the engagement with that hospital sector had a more tangible effect in the partnering for us in the early days. Certainly in Western Australia they work very differently compared to how Queensland services are set up and they often contract out to others. We do work with some of their community providers like pathology and other areas as well as the Mental Health Commission there.

CHAIR: I would like to thank both organisations for coming in to present today. We certainly appreciate the work that you both do in the community and in health generally. The presentations you have given here today and your submissions will certainly inform the committee's report going forward and help us to form our recommendations. They are interesting organisations, both filling needs that were not being met beforehand.

Ms Arro: Thanks for the great questions, too.

CHAIR: Thank you very much for your presentation. I will now take a short break.

Proceedings suspended from 11.00 am to 11.19 am.

CHAIR: I reconvene this hearing of the Mental Health Select Committee.

BLACK, Ms Jennifer, Chief Executive Officer, Queensland Alliance for Mental Health

CHILDS, Ms Sarah, Director, Sector Engagement and Development, Queensland Alliance for Mental Health

GRIFFITHS, Ms Emma, Director, Advocacy and Communications, Queensland Alliance for Mental Health

McLEOD, Ms Sally, Project and Policy Officer, Queensland Alliance for Mental Health

CHAIR: I would like to welcome representatives of the Queensland Alliance for Mental Health. Would you like to make a very brief opening statement after which we will go to questions from the committee?

Ms Black: Thank you very much for the opportunity to present. Can I first acknowledge the traditional owners of the land on which we meet and pay my respects to elders past and present.

We know that you have already heard from many other organisations. We know that you have heard about how dire the need is. We know that you have heard about how flawed the current system is, about how it is not fit for purpose. We also know that you have read the statistics in our submission. We know that Queensland is a really diverse state with vast distances and remote communities. Many of those communities do not have access to the services that currently exist. We know that mental health care is personal, so one size is never going to fit all—like the farmer in Rockhampton, who is probably not likely to sit in a psychologist's office talking about his issues.

What I want to do today is not tell you what you already know but to paint a picture of how it could be different and how you as law-makers, as representatives of your communities, can start to work to make a difference. Let us imagine a person in your electorate. This person has been feeling low, has not been sleeping well, has few friends and is really starting to isolate themselves. Perhaps they have lost work during the pandemic and now their house has been flooded. If you meet this person in your electorate office they rarely smile, they are not making eye contact and even you know there is something not quite right.

Most clinicians would say that this person ticks the boxes for depression, and that is probably likely. At the moment this person might get in to see a GP, who has limited time and limited resources at their disposal. In Australia they are very likely to get a script for antidepressants and possibly a referral to a psychologist. The wait time for psychologists might be months and the cost prohibitive for a vast majority of the population. You already know this. If the depression reaches a crisis point that person might have no option but to turn up to the emergency department. We already know that that is far from ideal for someone who is in acute distress.

Here is how it could be different. What if this person could go straight to one of our community organisations where there they find a warm greeting and a willingness to help, possibly from someone who has already experienced what they have experienced, so someone with a lived experience? The service has a range of programs and initiatives that create an environment for that person to process what has happened to them and to develop the skills necessary to build on their own self agency, to enable them to re-engage with their communities, to enable them to seek new employment or education if that is what they need, to enable them to secure housing and, ultimately, to enable them to live their best life.

The more than hundred services and individuals we represent do this work already and they do it through individual coaching across multiple domains: housing, employment, education, and social and community connection. Please do not think I am talking about life coaching. This is something very different, with a mental health lens.

If this person also needs medication or a psychologist, there are people at the service who can facilitate this. More importantly, they have received supports early in the episode of their distress. Since not all mental distress requires a medical solution in the first instance, they may not always need a GP, medication, a psychologist or an emergency department, leaving those resources available for those who do need them, easing the pressure on the acute system. This is a different way of addressing the epidemic of mental ill health and it would support the hundreds and thousands of people, the so-called missing middle, which I know you have already heard about. These people are currently missing out on any kind of care.

I trained as an occupational therapist and I have worked for nearly four decades in the public mental health system, the private mental health system and the community sector, both here and in the UK. For over two years, from 2017 to 2019, I was the deputy mental health complaints commissioner for Victoria. Since then I have been the CEO here at the Queensland Alliance for Mental Health. I choose to work in the community managed sector because I believe in it and so do many people with lived experience of mental distress. I know that our sector could do so much more. It could play a key role in a system that is strongly reoriented towards the community-based treatment, care and support in a system where there is a commitment to offering genuine community-based alternatives to hospital or crisis-based care, a system which recognised the benefits of care for people in their own communities close to their homes, families, carers and friends. This is very different from how care is delivered and experienced by people here in Queensland,

You might be asking me, 'How do we as law-makers make a difference?' There are system changes and there are funding changes that you could recommend. Here is what you could do. You could create realistic alternatives, community alternatives, to emergency departments for those in crisis. We could develop warm entry points and locally-based community services to meet the specific wellbeing needs of your communities so that people can seek help early in distress without first having to go through a medical pathway or have a diagnosis. It would require investment, though, in a workforce strategy beyond the clinical workforce to develop career pathways into the community mental health and wellbeing sector. We would need to invest in evaluation but allow enough time and resources for these sorts of initiatives to really be shown to be alternatives to what we already have.

We would like to see the commission have a greater independence and a greater remit over some of the other social determinants that really impact on mental health, and we would like to talk to you a bit about the work we are currently doing with the commission at some point. It will take funding and we already know that the investment in the community managed sector is lagging in Queensland.

The Australian Institute of Health and Welfare 2020 data, the most recent we could get, says that we have had an annual decline of 15 per cent a year since 2015 in our sector. We have the second lowest investment in the country for the non-government community sector, second to Victoria which we now know has had a $3.8 billion boost to their mental health system. I suspect we are now the lowest. The investment in the non-government sector in Queensland is 35 per cent lower than the national average. The 2020 funding for the sector was sitting at the same level as 1999, despite what we know about demand for mental health services. We also know from the commission's submission that only four per cent of the state mental health budget goes to the NGO sector.

If we truly want the best outcomes for Queenslanders, we need to put the community back in community to build our collective wellbeing. This has never been more important than as we enter our third year of a pandemic and recover from yet another natural disaster.

I am happy to take your questions, but I would like to table a report we have produced which talks about the vision we have for the community, if that is possible.

CHAIR: Sure.

Ms Black: We have copies for everyone.

CHAIR: Your submission talks about a community wellbeing model. I assume that is the sort of alternative pathway that you have just outlined. It anticipates a system without referrals or diagnoses. From an accountability perspective, how do we measure outcomes if we are not identifying specific problems and work out if we have fixed those specific problems, which is generally the way we have operated in a clinical sense?

Ms Black: I think we often, in clinical settings, measure throughput. I think we need to get clear about what the outcomes are that we want for our community. Wellbeing in the community is a much broader thing, is it not? The Productivity Commission talked about the cost of not looking after people's wellbeing. There are lots of ways to measure that. I would put to you that people do not really want to enter a mental health service or go and seek help unless they have something going on for them. We need to be clear about what we are measuring in that: what are the outcomes for individuals and what are the outcomes for the broader community.

CHAIR: In terms of that model you described, how does somebody find their way to that model?

Ms Black: That is why it needs to be visible in the community in some way. It needs to be an open front entry that is not stigmatised by some kind of medical clinic and a place that people can go where they can seek resources, they can seek some short-term help or referral on to something more

significant, if that is what they need. We need to normalise help seeking. I think the problem is when we fund more of the same, we fund more clinics. It adds to the stigma for people. We need to somehow get to a point of not stigmatising that help and helping people ask for help.

CHAIR: Thinking like a clinician again, imagine a scenario where you have someone who is in quite a significant severe psychotic episode and damaging property and is a potential danger to themselves. As a paramedic or a police officer transporting that patient, at the moment you would transport them to an emergency department because that is available 24/7 and your duty of care would end when you hand the care of that person over to somebody you believe is qualified and capable of taking care of that person. In the environments that you are describing there, how do we deal with those duty of care issues for those people who might be in those roles?

Ms Black: I think these sorts of services need to be delivered in partnership because it is not an either/or, it is a continuum. If you are working closely with a clinical service you can dial that up if that is what you need. I think what we are saying is it just needs a warm front end that is non-threatening for people to enter. You might find some of that de-escalates. Certainly in some of my previous roles I think the environment of the emergency department can be escalating for people in itself. Really the theory around that is to have a warm, inviting environment. Sometimes people are going to need to get a different type of care, but it is about providing those alternatives for people.

CHAIR: In terms of funding, we have an incredibly large economic experiment going on in the implementation of the NDIS over the last nearly a decade, I guess. We know that a lot of community organisations have lost funding, with the idea being that the individual is then empowered to go back and buy back those services. That then seems to diminish the capacity of community organisations to do a lot of that sort of generalist population level health. Has that had a significant impact and do we need to adjust for that as we move forward?

Ms Black: Absolutely. I think that has had a significant impact on a lot of our members through the introduction of the NDIS. I am sure you have heard people talk about how that was not fit for purpose for mental health. It was a disability initiative and really did not take into account the episodic nature that you might have with mental illness. I think what has really happened is that it has meant that for some of our organisations it has created a bit of a workforce issue because you need to dial up and dial down quite quickly so it has kind of casualised some of that workforce. That is a problem because a lot of that workforce is women. It kind of adds to that whole issue too about the workforce. Would one of my colleagues like to say something about the NDIS?

Ms Childs: I think we have definitely seen the inability of our community mental health services to meet the needs of anyone approaching their service because every service they are funded to provide is ring fenced by specific eligibility criteria and gates that people have to jump over to get into their services. If you do not meet that eligibility criteria they are not funded to provide you a service. The NDIS has really made that a much more difficult thing for our members to be flexible in what they are providing. What we are proposing in the community access to services would mean that people can approach the service and can get a service without having to meet that strict eligibility criteria—a service for them for where they are at in their community at that time.

CHAIR: You mentioned the need to move beyond a clinical workforce and develop some sort of new non-clinical mental health workforce. Can you take us a bit more deeply into what that means?

Ms Black: Yes. A lot of the reform we have seen around the workforce focuses on what we call the big five: doctors, nurses, psychologists, OTs and social workers. But we know that the mental health workforce is made up of more than that. It is made up of counsellors, telephone counsellors, creative art therapists, community and psychosocial support workers, peer workers, personal care assistants, recovery coaches, alcohol and other drug workers, social workers, OTs, psychotherapists, managers, volunteers—the list goes on. We focus our energies on building a workforce on the five big clinical workforces and we need real investment to create career pathways for people into the community sector. There are some specific skills that we could build and teach that would allow people to work in this kind of coaching way that we have been talking about, but we do not really invest in that. For our organisations, they tend to have to build their own workforces. They tend to have to invest in their own training rather than have a clearly developed pathway for people to go into those sorts of careers. There is a piece of work that could be done around that and that might help some of the skills shortages we particularly see in regional and remote parts of Queensland.

Dr ROWAN: Thank you to the Queensland Alliance for Mental Health. One of the things I took away from your detailed submission—and thank you very much for it; the term was battle weary from the many reviews through the Productivity Commission and other areas—was that you clearly articulated that population approach in dealing with the missing middle, which you have talked about

again today, and those system and funding changes. There are three things I have really taken away. There is a need for a workforce strategy around communication and population wellbeing, that non-clinical workforce that you just outlined before. More funding for the community and non-government organisation mental health sector is needed. The final one I wanted to come to, to translate your submission and what you are trying to achieve into reality when it comes to greater independence for the Queensland Mental Health Commission, to drive this from a governance perspective and a government perspective is whether you need a standalone cabinet minister for mental health so that you take the Mental Health Commission and other parts of the system that you need to drive that strategy of all the things that need to happen, not only in relation to health but employment and education and the population aspects of this, which are not just health related because when it is all linked to health often it is seen through the prism of clinicians and clinical services—the big five that you talk about, but there is this other big piece. I am trying to understand how as legislators the government could drive that at that very strategic level so that it then translates to what is needed on the ground, not just in one community or one region but across the state.

Ms Black: I think a minister, as long as they are part of the cabinet. In other jurisdictions we have seen an assistant minister and therefore they are not part of the conversation. They absolutely have to be at the top of the conversation. But, yes, I think that would be a great idea. That would allow then that whole-of-government approach across all of the other portfolios.

Ms KING: Thank you for your detailed submission. I want to turn to your comments about the need to destigmatise help seeking. Yesterday we had a site visit where we went out and visited Mates in Construction and in the context of possibly the heightened stigma in male dominated workforces and, for want of a better word, blokey workplaces, I suppose, they talked very clearly about the need for a help offering model where the emphasis is on creating capacity amongst the community to reach into a person's life when they are showing signs of being in crisis and seeking to connect them. I wondered if you had any comment on that.

Ms Black: I think that is right, is it not? That is kind of my point about perhaps that person not wanting to sit in a psychologist's office. Sometimes when people are in distress they need some practical help and some mates around them. That is why I think it is a whole-of-government approach so that you can have a range of initiatives that kind of help communities build what communities need. One of the things we see is models rolled out across the state, but that is not going to work in Rockhampton or Roma or in Mount Isa. You really need those communities to come together to work out what are the solutions that those communities need. You need people with lived experience at the table to be talking about what would have helped them when they were in crisis and build those models around the communities.

CHAIR: The Productivity Commission talked about localised planning and it seemed to focus on the role of perhaps HHSs and PHNs being engaged in that, but it did not seem to leave any defined role for the community sector. What would be your views in terms of some sort of localised regional planning and how that should roll out?

Ms Black: At the moment the NGO sector is either funded through the state government through grants or through PHNs or NDIS. Absolutely I think there needs to be local planning about what is needed. I think the big thing for me is that you need people with lived experience there. I think one of the problems is when we get clinicians around a room talking about what should happen we get more of the same. I think people are asking for something different. I think whatever the planning is it needs to be localised and it needs to include people who have experienced this because then you can build a system that people will want to go to and where they will find help.

CHAIR: Speaking of more of the same, I want to get on to the emergency departments and your suggestions around that. There are a number of trials going on around the state around alternative entry points to emergency departments. We saw one on Tuesday up in Hervey Bay, the Oasis crisis support service. Do you have any thoughts in terms of these trials that are going on around alternative emergency departments or are you looking at completely separated organisations?

Ms Black: I think one of the risks of having them so closely associated with the emergency department is they become more of the same. I do not know anything about that Hervey Bay one, but I think that is one of the risks. If you get a clinical service to run it you get more of a clinical service. There have been some examples. One of our members Brooke RED had a community house for a while near the hospital, but not next to the emergency department. That was staffed with peers who could meet people when they were in distress.

Ms Griffiths: Was that around Mount Gravatt? Where was that?

Ms Black: Redlands. I think that there are models that look at a partnership between the NGO and the clinical service—because you need the back end to get people into clinical services if and when they need them—but the front end should look very different from the emergency department. One of the risks of having it on the hospital grounds or next to the emergency department is that it just becomes an extension of the emergency department and does not offer a real alternative for people.

Ms Childs: In some of those crisis support spaces, people are still having to present, be triaged and be assessed and waiting long hours in the emergency department before they are funnelled into a safe space or a crisis support space. Some of our members are running some of those spaces in partnership with the HHS, but they are open only for a small number of hours. I think the funding is going to run out, as well. It is another pilot. Funding will run out, I think, at the end of next year.

Dr ROWAN: In relation to the additional funding that is needed by community and non-government organisations, does the Queensland Alliance for Mental Health receive feedback in relation to housing, education and employment? Are there any recommendations that you would give around specific things needed in specific parts of Queensland? Is it the same in urban areas, as opposed to rural and regional areas?

Ms Black: I think there are differences. There are some rural and remote issues, particularly around housing. We have done a piece of work on housing post the pandemic because we know that in some of our regional communities, tent cities have popped up because people have been squeezed out of their rental accommodation because of the squeeze in the market. Each region will be different. That is why we think that there needs to be planning around each of those regions. Housing is one thing, but you also need to support people who have been made homeless and who have lost everything. You need to support them in that process.

Ms Childs: Our piece of work was a housing position statement that we did in partnership with QShelter. It models what we think would work best—that is, mental health working in partnership with housing. We are encouraging our members to work with community housing providers so that people have tenancy support, they have mental health support and they might have drug and alcohol support wrapped around them all in the one space.

Mr O'ROURKE: In your submission, you talk about pricing the structure of the NDIS to accurately reflect the challenges associated with delivering services in rural and remote areas. Could you expand on that?

Ms Childs: Sure. The pricing that agencies receive for providing supports definitely does not include enough funding for supporting their workforce, for educating their workforce and for supervision. That is even more difficult and important in rural and remote areas where you might have people working alone. They do not have that team support around them.

Ms Black: I think the other problem is the thin markets. There are not services in parts of Queensland. It is a great idea that people can have a choice around services but if there are not any there, it is a moot point.

Ms Childs: People are not going to set those services up there when they lose money. It is not sustainable.

Mr O'ROURKE: Looking at different housing solutions in the model, the intention is that no-one should ever be discharged from a health service into homelessness. Are there any particular models that you have seen that you think would work well in Queensland?

Ms Childs: There are lots of models, and there are lots of pockets of good programs. We have highlighted some of those programs in our housing position statement.

Ms Griffiths: We will make sure that it gets to you, Mr O'Rourke.

Ms Childs: One of our members, Communify, work closely with a community housing provider. Communify have a specific tenancy support person to help a person to maintain their tenancy. They have a mental health team. They have a drug and alcohol team. A person has everything there to support them to successfully maintain—

Mr O'ROURKE: Is it a long-term housing solution?

Ms Childs: Yes. The issue is that a lot of these programs are time limited, absolutely. You get that support or housing for three months or six months. You definitely need the support and the accommodation—I was going to say life-long.

Ms Black: Longer term than it is.

Ms Childs: For how long people need it.

Mr O'ROURKE: In Rockhampton, we established Oasis house quite a few years ago which is a step-down model which was managed by the community sector. It worked fairly well, but I am not sure where it is at these days.

Mr MOLHOEK: In your opening address you spoke about community health and wellbeing, and the community alternatives to ED. Were you talking about community-based services specifically for mental health or were you talking about the fact that there needs to be a greater focus on the socialisation of community through sport, church and bridge clubs—in those broader spaces?

Ms Black: Probably both. We know that a large proportion of people who seek mental health care have experienced some kind of trauma, so it is important that the kind of approach we use is not re-traumatising for them. There is an issue about the alternatives to hospital, but I also think that there is a broader piece we can do around connection to community.

Some of our services already do that and try to work with people to get them re-engaged in their local communities. There is a lot of talk about social prescribing and working with community organisations that are naturally occurring in all of your communities to be part of the solution. We have partnerships with QSport and the Australian Council of the Arts to look at piloting some programs around connecting people into their naturally occurring community resources. There is a lot that can be done that does not necessarily just sit in health; it sits in a broader remit.

Ms Griffiths: I am relatively new to the sector so I have had to step my way through understanding it. The agreement with QSport is aiming to help people who are accessing our mental health services who are interested in a sport to get easier access to a local sporting club—not so that they can join a mental health team, but so they can join the team, or they can volunteer at the club, or they can be a valued member of that community. That gives them another way, hopefully in a welcoming warm space, to re-enter their community and to gain some confidence.

Mr MOLHOEK: It strikes me that maybe part of the solution is instead of spending more money on mental health we should strip away the red tape which discourages people from getting involved in local sport and makes it expensive, so that more people can participate.

Ms Black: Yes.

Mr MOLHOEK: A lot of people do not want to participate in local sport and committees because they have to pay rates, directors' liability and insurances. It is $300 a season for kids to register because you have to have 14 levels of insurance. I wonder whether we have created the systems that are causing the problem.

Ms Black: I think it is prohibitive for some people to engage in that, but we also know that it is a protective factor to belong and to have that social connection with your community. I think you are right.

Ms Griffiths: They still may need the community mental health service to help them take that first step in there, though.

Ms Black: Mainly because we are dealing with stigma in our community. I think that is why people often do not engage in some of those community activities because we do not a general awareness and there is stigma associated with their efforts to join a local community group.

Mr MOLHOEK: It is not affordable for a lot of people or a lot of families now.

CHAIR: Being a nurse who has mainly worked in the physical side of things and never had much experience on the mental health side of things, you would have to have your head buried in the sand in this committee not to have heard the level of distrust between people who use clinical services and those clinical services. It is surprising to me because on the physical side of things we never get anything wrong and everyone walks away completely happy and we have no problems. What does concern me—in the language you have used today, the language we heard yesterday at Maters in Construction and the language I have heard over and over—is that there is that real sense of distrust. There is an ongoing need for clinical services. There is going to need to be doctors, allied health professionals, nurses and emergency rooms et cetera. Now we are advocating another service and another institution, which is community-based. Inevitably, there will be people who are unhappy with that approach. How do we get back to a point where there is a partnership in delivering good health outcomes for people and move away from this us versus them type of mentality that seems to exist in the mental health space?

Ms Black: I think you are right. I think there is distrust. I think people have had experiences that have not been positive. That is very well known. It does need to be a partnership. These things should be complementary—not one or the other. I think what this sector can do is take some of that pressure off. If we get that right, we can take some of that pressure off. We can create better

experiences for people who are trying to seek help. We can do that early in their distress. I do not think it is an either-or. I think that our sector is more than capable of working in partnership with clinical services. It is probably a two-way issue that we need to deal with, but I think it is possible.

Dr ROWAN: On the one hand we have the clinical system and then on the other hand a 'population approach', as I would term it. We are talking about a whole-of-government strategy, particularly around the psychosocial determinants of health. Trying to assist people is obviously defined by where they live, their education or employment opportunities, the self-esteem they get through being connected with their communities in sporting and other community organisations and empowering that. Taking a whole-of-government approach, is there any jurisdiction that you know of that is doing it well—whether that is in Australia, or internationally, where you could say that their whole of government approach is delivering some great gains or improvements in the system in improving the psychosocial determinants of health?

Ms Black: We always quote New Zealand because they have certainly put together a wellbeing budget and have started to think about that. I am not on the ground so I do not know how that is actually playing out, but I think there are some examples that we could look at and draw from and find out a bit more about. They talk about 'mental wealth'.

Dr ROWAN: That would be great if you could take that on notice. If there is any additional information we could have on that, it would be appreciated.

Ms Black: Absolutely. I am sure we could find some things and send them to you.

Dr ROWAN: Thank you.

CHAIR: Thank you very much for your presentation here today. It has been extremely useful. It will certainly inform our report and our recommendations going forward. You have painted an interesting picture of an alternative model which has been very useful for us to understand more about and certainly builds on what was in your submission. On behalf of the committee, I would like to thank all of your member organisations as well for the work that they have done over the last couple of years. It has obviously been a very difficult time for anybody in the health space with the pandemic going on. Please pass on our thanks to them. You have taken a question on notice. We will need the response by close of business on 18 March.

Ms Black: Thank you very much.

CLAY, Ms Naraja, Person with lived experience, Mental Health Lived Experience Peak Queensland

ELWYN, Mx Rosiel, Person with lived experience, Mental Health Lived Experience Peak Queensland

GULLESTRUP, Mr Jorgen, Chief Executive Officer, Mental Health Lived Experience Peak Queensland

CHAIR: I welcome representatives from Mental Health Lived Experience Peak Queensland. It is a pleasure to have you here. We have Mr Jorgen Gullestrup, who is the Chief Executive Officer; Rosiel Elwyn, who is a person with lived experience; and appearing for the second time today we have Raja Clay, another person with lived experience. I invite you to make a brief opening statement and then we will move to the committee for questions.

Mr Gullestrup: Thank you very much. My name is Jorgen Gullestrup and I am the interim Chief Executive Officer of Mental Health Lived Experience Peak Queensland. I want to start by acknowledging the traditional owners of the land on which we meet and pay my respect to elders past, present and emerging. The peak is a very new organisation that was established particularly for the purpose of giving a collective voice for people with lived experience in terms of systems, advocacy and policy advice.

With me today I have Raja and Rosiel. Both were part of the Lived Experience Advisory Group, who co-created the submission you have in front of you. They will share some of their unique experiences. However, their experiences are broadly representative of what we have heard as part of putting this submission together.

In your inquiry so far you have no doubt heard about the lack of resources. You would have heard about the need for more beds. You would have heard about the need for more community resources. Of course we support all of those calls. There is a lack of investment in mental health. We know that. It is real. This submission here is perhaps more about what actually happens to the people in those beds and to the people who engage with those services as they do that.

As a committee you have a great responsibility and an important choice. You can produce a report that would enter the library, together with hundreds of other reports we have had on the mental health system over the last hundred years or so, or you can decide that this inquiry will be the start of creating a new system within Queensland that is more suitable for the people who might engage with it. We believe that in Queensland we deserve a mental health system where you do not have to give up your individual rights to get support, where you do not have to give up your human rights to get support, where you do not have to give up your cultural rights to get support, where you do not have to pretend to be a different person to who you are in order to get support, and that we create a system where the focus is on you as a person, as a whole person, rather than the diagnosis we label you with.

I am pleased that you met with Mates in Construction yesterday. It is an organisation I have more than a passing interest in. When you look at Mates in Construction you can see what is possible when we start by looking at the consumers who use the product and design something from their perspective out.

In our submission what we are really asking you to do is to try to rethink the system to a system where we start changing the balance of power within it, where we give greater voice to those with lived experience who know how the system works, where we have greater use of the peer workforce within it, where we reform the system to make it culturally safe for our First Nation Australians, where we make it culturally safe for those of us who have different ethnic backgrounds and for those of us who have different identities and different issues, and where we the system considers the whole person—where a place to live, a job, the right medication and the right treatment is all part of the outcome we are trying to achieve. That is probably all I want to say as a lead in. I will hand over to Raja and Rosiel to introduce themselves.

Ms Clay: I am here this morning to talk from the perspective of being a young Aboriginal woman who grew up in out-of-home care in Queensland. As a result of my early childhood experiences, I live with a diagnosis of complex PTSD and a range of other chronic physical and mental illnesses.

Mx Elwyn: Thank you for the opportunity of speaking with you today. My name is Rosiel Elwyn. I have a Master of Psychology and I am currently studying my PhD in neuroscience and mental health. I am currently thriving and doing well but that was not always the case.

I have been a service user of the public health mental system in Queensland in a variety of hospitals. I was also a user of the child and youth mental health system as a child and an adolescent and then frequently hospitalised as an adolescent young adult and as an adult. I have been treated for a variety of mental health experiences including multiple suicide attempts, self-harm, depression and psychosis and severe anorexia nervosa. I am also autistic and I identify as an LGBTQ person. These aspects of my identity impacted on how I received treatment, because I often experienced discrimination within the mental health system. Those are also experiences of my care. I had some traumatic and harrowing experiences of care but I also had some really compassionate experiences of care.

I worked as a peer support worker for 12 years. Those experiences also inspire my drive to pursue psychology. While pursuing psychology because of my lived experience I also encountered discrimination. Because I was so passionate about mental health care and was driven to see the mental health system in Queensland improve, it was like that door closed, so I was trying to find another way in to be part of what we are all so passionate about—mental health care in Queensland. That inspired my decision to pursue research. I am one of those people who could not find a way to say no.

Mr Gullestrup: Hence you are here.

Mx Elwyn: Hence I am here. I welcome questions about my lived experience.

CHAIR: Be careful with that. You will end up on this side of the table if you cannot say no to people! Thank you both for your presentations. It is a challenging submission that you have put forward as an organisation. I want to thank you for that. Jorgen, you repeated the challenge to the committee about the choices that we have. One of those choices was around a system based on diagnosis and risk assessment and another based on cultural, social and safety needs of people who use the system. Is it possible to have both of those systems running in parallel?

Mr Gullestrup: That is what we have heard when we have spoken to people with lived experience about this. It actually works best when we do both—when the whole person has a diagnosis but that sits within a context. Some of the things we talked about before we came in here was that how we understand things is often very diagnosis driven, but when we start to understand things in a social context we get a different picture of it. We discussed how psychosis is often seen as something that is not understandable and needs to be suppressed and confined and so on, when quite often it is a way that people try to express themselves and talk about the past trauma they have had. I think things can exist side by side if we are prepared to give up some of the power dynamics we have within the system today.

CHAIR: Recommendations 3 and 13 envisage, in my opinion, an absolute overhaul of the way we deliver government services. Raja, you mentioned your experiences of growing up in the out-of-home care system. Rosiel, you mentioned your experience with CYMHS and, subsequently, you have moved into the institution of tertiary education. Can you give us some indication from both of your perspectives of how we might achieve this radical rethinking of government services?

Mx Elwyn: I am now in remission from psychosis and medication free. The turning point for me from that was experiencing peer support. Clinicians were putting me on antipsychotic after antipsychotic, saying, 'How is she not getting better? She is actually getting worse.' They were putting me on heavier and heavier antipsychotics. What this was doing for me was that I could not express myself. My emotions were being completely shut down. I was getting more and more suicidal because my life was meaningless. My body was almost immobilised. I was at home becoming completely disabled. People were having to feed me because my body was so disabled by the heaviness of the antipsychotics. As someone who was very creative, I could not do art anymore. I could not think anymore. I could not express myself. My life was so meaningless.

I made the decision to go off the antipsychotics against medical advice because my life was so meaningless at that point. All of a sudden my life started to have meaning again because I could feel my emotions. I started to key into the trauma that was linked to the psychosis. I could start to move through that trauma and start to link it to what had happened that led to the breakdown and led to the mental health problems that started to happen.

I had been cycling through hospital for years and years. Once I started to be able to key into those life events and the constellation of factors that had led to these experiences—all of the violence, all of the trauma, all of the things that had happened to me—and talk to other people, re-engage with the community and start to do things like study and art, I could reconnect to myself as a human being and reconnect to other people. That started the healing process. Over time, it really became this slow

gradual process of healing. Then all of a sudden I did not have to be in hospital so often. I was not frequently self-harming and suicidal anymore. I could start to make slow improvements on my eating disorder and things like that.

It was not this constant crisis cycle. That took the burden away from people having to care for me as well. They were not having to fear: 'We cannot take our eyes off her for a second.' All of a sudden it was no longer this idea of having to be dependent on medication to contain the psychosis. It was reframing it from 'the psychosis must be contained by medication' to think that something has happened: the psychosis has meaning. If we stop looking at it as an illness and link it to meaningful things that have happened in your life along the way and look back—once people started asking me what happened and what I thought the psychosis was linked to and we looked back through my life at lots and lots of events that were really critical, stretching right back through my childhood, it changed everything.

When I worked as a peer support worker, I was seeing the same sorts of things. I was hearing the same stories from other people—the same narratives would often happen to them. Once they could start looking at the narrative of their life and reconnecting to the meaning in their life, reconnecting to the context of their life, they could step out of this crisis of revolving doors of services.

CHAIR: Where and how did you connect with the peer support worker?

Mx Elwyn: It was something I looked for myself because I was desperate to get away from being completely immobilised by medication. I was desperate for hope so I started looking for memoirs because I was like, 'Other people have recovered. I know other people have recovered from mental illness, I know they have.' I could not even read more than a sentence at a time because of the strong medication they had me on. They had me on clozapine. They had me on so many drugs. I was a teenager. They had me on a cocktail of medication. I could not even feed myself. I had family members having to feed me. It was horrendous.

I would read a sentence at a time of these memoirs that I was borrowing from the library that were recovery mental health memoirs of people who had recovered from schizophrenia, bipolar disorder and things like that. I was like, 'There has to be something like this. I know there are these sponsor models of people with drugs and alcohol. There has to be something like that for other mental health conditions.' I started looking up online something like that. I typed in things like that and I found peer support models. I found hearing voices groups, bipolar support groups and things like that. When I found those community support groups of people talking about their experiences and connecting with community members, I got involved with those. Then after I was hired as a peer support worker when I was more recovered—and I have been recovered for a while—I started working in those models. That was my turning point.

CHAIR: Thank you. Naraja?

Ms Clay: Sorry, I lost my train of thought. Could you re-ask the question?

CHAIR: In recommendations 3 and 13 of your report there is a radical reimagining of how government services might be delivered. I want to understand your experiences of the government services that you would have encountered while growing up—you were probably at an age where you probably did not understand that they were government services—and maybe what those recommendations mean for you?

Ms Clay: In my early childhood—I could not even remember what was going on—I was seeing my GP very regularly. There was a conversation that I had toxic stress, but there was no further conversation, 'Well, what do we do with this now?' That resulted in me experiencing mental health concerns for over a decade. Due to the lack of appropriate and safe support and services, I experienced a lot of discrimination in terms of help seeking. I remember going to hospital because of suicide attempts and the clinician I talked to would say, 'Well, you are not actually serious because you did this instead of this.' They were not forthcoming with the support that I was looking for. I received a lot of patchy support over the years. I was diagnosed with bipolar at 19 after experiencing a manic episode. That then got the ball rolling on looking at further support. That is where I was later diagnosed with complex PTSD.

As a result of that and when COVID hit that compounded all this hectic trauma. I accessed the public mental health system for support through inpatient services. It was one of the most degrading experiences of my life, to the point where, because I was not clinically underweight, the clinicians I would speak to would be adamant that I did not have an eating disorder and that I was just depressed. I also had clinicians threaten to put me onto treatment authorities because my recurring presentations to the emergency department meant to them that I had a lack of capacity and understanding. To sum

it up, pretty much my experiences with Queensland's public mental health system in the past two years were so bad that I ended up getting private health insurance just so I would never again have to access Queensland's public mental health system.

CHAIR: Have you had different experiences in the private system? Have you had any experiences?

Ms Clay: Yes. I was not able to get the support that I needed for an eating disorder with the public mental health system. I was referred by my GP to Eating Disorders Queensland, which is community based. That has been incredible. It has been the best support that I have been able to receive and it is long-term. It is not just when they say, 'You are clinically stable; see you later.' They offer to do the trauma work, DVT type work and different things like that.

CHAIR: They used to be in my electorate and then they moved.

Dr ROWAN: Thank you, again, for the presentation today. Do you have any thoughts or recommendations around peer support workers? Obviously there is a huge group of people with lived experience. What are the best qualities for people who can become peer support workers? In other words, are there particular factors you look for? Apart from people's personal lived experience, are there other things you look for, particularly when considering recruitment, peer support workers in a range of services, whether they are in community or in the Queensland Health system? How do you find those people who would be really good peer support workers?

Mx Elwyn: As I have studied a Master of Psychology and worked as a peer support worker, I have a foot in both camps. The importance of the peer support worker is that while there is distrust between patients and clinicians—I have had some really traumatic experiences in the public health system in Queensland—I do not necessarily see that as clinicians wishing to do harm. I often thought that it was because of the models being used. The frameworks that clinicians and nurses were coming in with were often harmful. The clinicians themselves were harmed by what they were doing. They were experiencing moral injury themselves. That was the way that I saw it. It was not that I even necessarily felt that people were wishing to do me harm, but that it was harm through the systems being used. I was often deeply traumatised by what happened to me. I was put in restraints. I was put in solitary confinement. Horrific and horrendous things happened to me and I had nightmares for years. Deeply dehumanising, degrading things happened. Mental health nurses often told me that they felt traumatised from witnessing what happened as well.

Peer support workers are really important for that bridge of trust and the sense of safety. People attracted to peer support work often come in with a sense that human rights are important and they see the vulnerability of people who have mental health issues. They can often be attracted by the sense of upholding human rights and values. Knowing that you can come and offer care, there is also this sense of, 'We are all here working for the same thing.' In some ways, there has been a breakdown in the way this is perceived. We are all working for the same thing, but somewhere along the line there has been this perception of a divide. In many ways, people who come to peer support think, 'We can be this bridge to bring it back together and become the multidisciplinary team that is helping patients feel safer so that we can help them recover and heal again.' We get to be that person.

That is an important value. If you can find peer support workers who have that mentality, that is something that I always try to come in with as a peer support worker. I was always working in hospitals where I had been a patient. Sometimes it can be hard. Burnout can be really high for peer support workers because you can be working in a place where you have been traumatised yourself or you are working with clinicians who treated you as a patient. That can be quite difficult. Some people find that so hard that they can only work for a short time. For some people it is too difficult because it is still fractured. It is still such an early model. Sometime there is just not enough support for peer workers, and they burn out and things like that.

Dr ROWAN: To paraphrase that back around peer support workers, it sounds like not only the lived experience but a strong sense of justice, empathy and compassion would be the sort of qualities?

Mx Elwyn: It is about awareness for what clinicians are dealing with as well. Burnout, compassion fatigue and moral injury is also a huge factor for clinicians. It is important for peer workers to also understand that clinicians are not the bad guys either. Mental health nurses are not either. The models themselves need a big shift. Peer workers need that sense of, 'We are working for the same thing. We want to support people with mental health issues. We want to work towards recovery. We can be this bridge to heal that sense of divide.' I perceive those as important values.

Mr Gullestrup: That is certainly some of the frustration we picked up when we spoke to people who worked in peer roles. Even when they work within the system they are put over in the corner and are not taken as a serious part of system. They are not valued for the serious part they are playing. Often we heard that people who are using the system found people like the security workers were the most helpful—the people who came in and tried to deescalate the system because the nature of that is to take the time to understand. When we talk about the system, we have to value personal understanding and personal respect on equal terms with good medical treatment. We are not saying either/or.

Ms Clay: I echo the human rights perspective. I am currently a peer worker. Prior to that I was a community visitor with the Office of the Public Guardian. I work in the royal and different places like that. I was there because I cared about the human rights of people going through that system. Unfortunately, there was just so much bureaucratic red tape that I could not do anything to help those people. When the opportunity for peer work came up, I took it. I get to support someone in their recovery as well by basing it off not just my own lived experience of recovery but using different models of support. We do some brief intervention work around DVT and different things like that, but I see peer workers and people attracted to peer work as people who care about human rights and want to support others through their recovery.

Mrs McMAHON: Thank you very much, ladies, for coming in and sharing your story. I am very interested in the peer workforce and note that you both work in that space. We have heard some interesting feedback and comment on the training that is available. Obviously, to be a peer worker there is a qualification. Not all people with lived experience, even those who have recovered, will be suitable to be peer workers. Can you comment on the training that is out there or at least the minimum requirements that are out there in terms of the certificate IV, accessibility, availability, support and whether we have enough, noting that the submission has recommendations for targets within the mental health workforce? What is your experience in the training and is it suitable for what you are doing? Do we need to re-evaluate that training? Is there enough to be able to meet your target, I think, of 10 per cent of all the mental health workforce being peer workers?

Mx Elwyn: I have had interesting experiences with that. Because I started peer support work quite a while ago, I think that was introduced even before the certificate IV was really well established. When I started peer support work there was what was called intentional care support training, which was a few months even of training, so it was much more based on interviews, weeks of training. I think they really highly valued the certificate IV, but by then I already had my Bachelor of Psychology and was studying my Master of Psychology, so they kind of thought of that superseded the certificate IV.

Mrs McMAHON: RPL.

Mx Elwyn: Yes, so that was kind of looked on as valued. I think a lot of the issues in terms of support for peer support workers themselves is that it can be a bit fractured. You might have a team where you might have someone whom you can debrief with, but I have worked with different hospitals and they seem to have very different approaches. You might come in and you might not be invited to the ward rounds at all, so it is very difficult to come in and support a patient if you do not know what has been happening with that patient at all during the week. You come in for your shift and you are given the sheets for patients, but you have three notes for each patient and you are not invited to the ward rounds, the ward meetings, you are not given any updates, and then you are expected to go and provide support to patients. You do not know what has been going on with someone, so you are scrambling to find out. You do not know if you are going to say anything that might be sensitive. You do not know what has been going on with their support network, their visitors and loved ones, things like that. It is hard to meet up with other peer support workers. It could all be very fractured. Things like that made it very difficult to do your job. In other hospitals you might have an office to meet with other peer workers, you might not. You might be trying to meet in hallways and trying to be respectful of confidentiality and not be overheard and things like that, so it could be very hard to do your job because there was not a space for peer support workers or peer support workers were not properly integrated into the multidiscipline routines.

In terms of training, there was not often specific training for different lived experience staff. It was all just sort of mish-mashed together. That was very difficult for me with respect to eating disorders because in many hospitals I was the only person with lived experience of eating disorders and the only peer support worker for eating disorders. That was very difficult because eating disorders are so physical as well. Nurses would be coming to you for advice for eating disorders on the medical side as well as the mental health peer support recovery side and you would be kind of saying, 'I'm not a nurse. I don't want to give you medical advice. I can give you advice on the recovery side of

what it is like to be someone with lived experience. I do have some medical knowledge from having gone through it, but I definitely do not want to be telling you what you should be doing with regard to someone's potassium levels.' I am not going to step into that side. I think there needs to be speciality training with regard to eating disorder peer support because there is so much around that. That is a kind of speciality knowledge. I think at some levels peer support training may be better. There needs to be high levels of support for peer support workers themselves rather than just how it is approached with how you are involved with the teams and things like that.

Mrs McMAHON: Just quickly, Jorgen, because I know we are going to run out of time: is it going to be part of your body's scope to monitor, manage, report and improve the training program in terms of the peer workforce? Is that something that is going to fall under your remit once the organisation is fully established?

Mr Gullestrup: The scope of the organisation is to represent lived experience. We have Mx Elwyn, who represents the peer workforce, so obviously it will be close consultation. I am not 100 per cent clear on what our role is. The last thing we want to do is create a peak and then duplicate what other people do really well. I think it is a conversation to find out where is best. Our role is very clear: it is about representing the people who use the system, but it is just so obvious that peer work is such a core part of making sure that the people who use the system are well cared for.

CHAIR: You talk about duplication. How is your organisation's mission statement different to, say, Health Consumers Queensland?

Mr Gullestrup: Health Consumers Queensland is a broad organisation talking about health consumers generally. We speak specifically to mental health consumers, specifically with an added focus on those who are disadvantaged and marginalised within the system. Our role is actually really to try and find the ones we have not heard. We are a little bit early in our life yet to be able to do that effectively, but it will be very much about trying to find the voices that we are often missing when we have these discussions.

Ms KING: I wanted to turn to some of the experiences you shared, and thank you very much for your honesty in doing that. It is not my place to say how sorry I am to hear those things happened, but I am. Specifically looking at early adverse events in the life of a child in particular, you talked about Raja sitting in the GP. Was it being mentioned that you had toxic stress from whatever source? Given we know that so much mental ill health in later life is grounded in those early adverse events—we have heard a lot of submissions about the ambulance at the bottom of the cliff versus the fence at the top and all of those things—do you have any views on what could be done better to support young people who are experiencing early adverse events?

Ms Clay: My experience of growing up in out-of-home care was just abysmal. I do not have any good words to describe it. Being able to access support that understood that—sorry, I lost my train of thought. Can you come back to me?

Mx Elwyn: When I first started having mental health issues I was eight. I already had anorexia by the age of eight and I was self-harming and I attempted suicide at the age of 12, so by then you already can see. For someone to have severe mental health issues by this stage, then obviously something has gone really wrong. I was in child youth mental health at this stage. I have an identical twin sister who was not having those mental health issues, so this is a perfect case study in itself of very different pathways. I was in child youth mental health and I was trying to say, 'Something is really wrong. I'm experiencing things at home, experiencing some violence, a lot of emotional abuse, neglect,' all of these kinds of things, but the approach that I was being given was very much this deficit illness model of, 'There are things wrong with you—things wrong with the way you're thinking, things wrong with the way you're feeling,' so nothing was changing. Even when I was being taken to child youth mental health I was experiencing abuse all of the way there, then all of the way back and then back in the same environment, so nothing was changing. Unfortunately, the care I was being given could not help. It was kind of reinforcing to me that it is my fault, that there is something wrong with me as a person, that it is my deficits that have led me to feel this way.

It was a very long time—years and years and years—before I could process that the mental health issues I have developed actually make a lot of sense. It was a long time before I understood that I had trauma. I understood everything within this illness deficit model. By the time I developed psychosis at around age 14 I had so much trauma. I had already been in the mental health system for a long time by then and I had so many dehumanising experiences, and then everything got funnelled through, 'You're psychotic.' By the time I started to understand trauma I had to start to unlearn all of those kind of deficit pathologising models. I think that becomes a problem of care. When you have a child who attempts suicide at 12 and has all of these severe mental health issues by the

age of eight, we should be asking questions about how can this happen. Also, how can they have an identical twin who does not have these issues? What could have happened to this person? Instead of that happening, we have a child youth mental health system model that is saying, 'There's something wrong with this child as a person with how they process their social world or how they have vulnerabilities as a person,' rather than maybe there are systems around them or maybe their world is unsafe. I think that was a factor. At least, for me that was a factor.

Ms Clay: I would say that for me one of the things that I struggled the most with was even if I told someone about what was going on, I probably would not have been believed, so that was a challenge there. But I think moving forward if my GP had understood what toxic stress was and understood that toxic stress was going to impact my brain development and it was going to put me at risk of developing mental illnesses, there could have been an holistic treatment plan developed. In the US there is a place called the International Centre for Youth Wellness, and they focus primarily on young people who have experienced adverse childhood experiences. They bring together a multidisciplinary team to support the young person in their journey, so probably getting into tertiary education and getting into the ear of GPs and talking to them about the very real consequences of a child experiencing toxic stress and how do you screen for that, how can you add into your questions when you are seeing a patient, check to see what their experiences are at the moment.

CHAIR: I want to thank you all for presenting here today. It has been most useful for the committee. It will certainly inform our inquiry and recommendations. Raja and Mx Elwyn, you have shared some pretty personal stories that obviously have been traumatic for you throughout various points in your life, but I want to remind witnesses that if anything you have shared today does trigger anything for you in terms of retraumatising, we do have resources available from parliament that we can make available to both of you. If you require that as well, if you cannot secure those resources internally in your organisation, please just reach out and we will be very happy to make those available to you. Thank you very much for your presentation.

DE GEORGE-WALKER, Dr Linda, Senior Policy Advisor, Australian Psychological Society

MURRAY, Dr Alexandra, Senior Policy Advisor, Australian Psychological Society

CHAIR: Welcome. I ask you to make a very brief statement and then we will go to questions.

Dr De George-Walker: Thank you to the committee for the invitation to appear at this hearing today. I acknowledge the traditional custodians of the lands on which we are gathered today, the Turrbal and Jagera peoples, and extend this respect to the traditional custodians of the lands where others might be joining from today. I pay my respect to elders past, present and emerging. I also acknowledge the contribution of people with lived experience of mental ill health or who are caring for someone with mental ill health and their role in progressing mental health reform in Queensland.

I am here today with my colleague, Alexandra, and we are from the Australian Psychological Society. We are also Queensland based APS staff who have lived and worked in a metropolitan, regional and rural context and understand many of the health concerns of our fellow Queenslanders and the opportunities that there are to improve the mental health and wellbeing in our community. As part of writing the submission, we also consulted extensively with members of the APS who work in mental health in Queensland in both public and private contexts. In the APS we have 27,000 members nationally and, of the approximately 7,500 Ahpra registered psychologists in Queensland, more than 5,000 are APS members. Of our Queensland APS members, about 45 per cent work in private practice, but less than 10 per cent work in public health and less than five per cent work in our schools, be that public or private contexts.

As the largest dedicated mental health workforce in Australia, psychologists have been on the front line during these incredibly challenging times in the past few years. We have seen a marked increase in the need for mental health support associated with the COVID pandemic, with youth and women especially impacted. The mental health impacts of the pandemic were confirmed yet again late last week with the World Health Organisation reporting the prevalence of anxiety and depression at a massive 25 per cent during the COVID pandemic. We also know that workplace injury claims for mental ill health in the states and territories are on the rise. This is alarming for individuals, families and organisations who are impacted with regard to workplace productivity and community participation.

Unfortunately, many people are unable to get the mental health care and support they need. Recent estimates are that in Australia we have only 35 per cent of the required psychology workforce. This is reflected in findings of a survey of our members earlier this year, which found that 88 per cent of psychologists have seen an increase in demand for services, that clients are often waiting three months to see a psychologist and some more than six months, and that one in three psychologists are unable to see new clients. For some context about this, consider that it was one in five in June last year, and prior to the pandemic it was one in 100. We can reasonably expect further increases in demand and wait times for mental health support for Queenslanders as a result of the ongoing impacts of the significant devastating flood events over recent weeks. It is well known that the longer a person waits to seek treatment the greater the risk of a condition becoming chronic, which means it takes longer to resolve and is associated with poor health outcomes. We know that costs the system considerably more in the long run.

The APS and our members are absolutely passionate about improving mental health in our communities. We have strategies to address the major issues and would like to partner with governments to deliver the solutions. Front of mind at this time is of course concerns for the mental health and wellbeing of Queenslanders and their communities devastated by the floods. The APS is represented on the National Coordination Mechanism. As part of our APS psychological Disaster Response Network, we provide training to psychologists who are then ready to respond to frontline workers working in flood relief and recovery.

We also need to urgently get traction around getting mental health practitioners into rural and remote communities. While the APS has welcomed the ongoing commitment of government to telehealth, there is still a desperate need for on-the-ground mental health support where people live and work. We have workforce solutions to increase practitioners on the ground in rural and remote areas that can be actioned with the right government support. We also want parents and kids to have the support they need from early in life right through the school years, gaining access to early intervention and preventing mental ill health downstream in adulthood. We urge the Queensland government to take immediate action to increase the rate of school psychologists to at least one psychologist to every 500 students. Psychologists provide effective, evidence based behaviour

change and cognitive change programs, and we urgently need to also get these out to the community for mental health promotion and reduction of stigma associated with mental ill health.

To make all this happen for Queenslanders, we urgently need to increase the psychology workforce. Within a short time frame of two to three years, we could easily scale up the number of fully trained psychologists with the right investment in postgraduate university training places with scholarships, sponsored placements, particularly in rural and remote areas, and supporting professional supervision. This investment would actually deliver immediately for Queenslanders, with the availability of our psychology intern workforce into mental health services. The APS would like to thank the committee for the opportunity to give the opening address. We look forward to your questions today.

CHAIR: I want to thank you for breaking your recommendations into state and federal government. That saves us a lot of thinking. I want to start where you finished and that is on the workforce because it is an issue we have heard time and time again. It is heartening to hear that you think we could actually move some way towards addressing that within two to three years. Could you step us through how we might deal with that? Are there also options around looking at scope of practice issues in terms of trying to address workforce issues?

Dr De George-Walker: Psychology is a popular area of study. We have many people who complete their undergraduate, which is four years, and they just do not have access at present to the training that is required for them to be registered as provisional psychologists. We are talking here about masters places.

We cannot expect the university sector to continue to make up the shortfall of offering these places. These programs actually run at a loss, so just increasing Commonwealth places is actually going to add more burden to the university system. We need the places plus we need support—so scholarships for students to attend places. That is something the federal government could do, but the state government could do that as well and work in partnership with universities and the APS to look at how to bring in scholarships and also placements in Queensland Health, for example. A big part of the training is supervised placement opportunities. Again, the state government could partner through Queensland Health and other public health services to provide those placement opportunities.

The third important part of that is that students must have access to professional supervision from experienced psychologists. This is about providing support for psychologists in public mental health services in particular, as well as private, to actually have the time and the resources to provide that supervision and to undertake the training they need to be supervisors.

Mrs McMAHON: I should declare as I have to the committee that I am one of those thousands of Queenslanders with an undergraduate psych degree but with no postgraduate studies because they just were not available at the time. Does the society have data on how many people Queensland-wide and Australia-wide are graduating with an undergraduate degree and then how many of them go on to complete qualifications that allow them to register? Do we have a percentage of how many potential qualified psychologists we could have out there who have been trained and done their undergrad over the last 20-odd years but have now moved off to organisational psych or HR and have used their psych degree for something completely different?

Dr De George-Walker: As a rough guideline we say there are about five times the number of graduates at that undergraduate level than places at the postgraduate level. I think that would give you a rough indication that we have got quite a workforce that we could scale up quite quickly in that two to three years.

Mrs McMAHON: Because I trained I obviously do have quite a few friends who did go on and register and have their own practices et cetera. The issue about placements and supervisors is something I frequently hear about, particularly since the Medicare rebates came in. There seems to be a large scale-up of the big multi-practices, where in many cases graduate students themselves are the ones seeing patients with limited or no supervision. I imagine this would be a concern for the society in terms of their registration and their supervision but also for the mental health and wellbeing of the people they are seeing, because they are seeing someone who is probably not as qualified as they thought they were.

Dr De George-Walker: Is that a question?

Mrs McMAHON: I guess the issue is around quality placement. Given the limitations that you have outlined about supervision and placement, how is your organisation making sure that those who do go on and graduate and register are getting that full suite of supervision? Could you point to some of those areas that we as a state government can help to facilitate more supervisors?

Dr De George-Walker: I will let Alexandra talk about public context, but when psychologists are provisionally registered there are very strict requirements set down by Ahpra that they do receive the minimum professional supervision. That is very well monitored. Yes, we have that assurance that that is occurring. Responsibility for that assurance sits both on the supervisee and the supervisor.

Dr Murray: Particularly in the context of preparing our submission to the committee, we have seen and heard from our members who work in the public sector and have highlighted some of the issues that you have raised in that there is a lack of placement opportunities within the public sector and there is a number of reasons for that. It appears as though the overwhelming demand and case load that everyone is carrying distracts from other very important tasks which, for example, helping train the next generation of psychologists, the overwhelming need for care and the overwhelming patient load. As well, because of that, for anyone who supervises it often appears that they have to do that in their own time as there is not time during their normal duties to undertake that supervision and to do the mandatory training that is required to be a supervisor. They even have to pay for that registration and training themselves.

Mrs McMAHON: In order to become a qualified supervisor, could you outline to the committee what the mandatory training looks like? What does it consist of and how much would it cost the individual psychologist?

Dr Murray: We can certainly provide that information on notice, if that is okay. We can give you the specific requirements and the costs and so on. I do not have that information to hand as yet.

CHAIR: That is fine.

Dr ROWAN: With reference to your submission on page 5, I have always been a supporter of industrial reform for health professionals. Referring to recruitment and retention, I know you touched on the rural, remote and regional workforce. I go back to an earlier question around scope of practice and psychologists being captured under a generic public sector award. Obviously in Queensland Health there is a medical award and a nursing award. Would you have any recommendations as to what could be done there within a stand-alone psychologist award for the purposes of recruitment, retention, career progression and utilising that additional scope for people with qualifications? Does the APS have some recommendations of what that could look like in Queensland?

Dr Murray: I do not know if I am able to specifically comment on the need for a psychology-only award, but certainly within the awards that psychologists work under, there is a need—and this has become quite clear from consultation with our members—as you mentioned, to properly recognise a qualification. For members who are not aware, the pay incentives and so on under this particular award end at a relatively junior level. There is not that incentive to then take on additional responsibilities to become a senior clinician because the pay difference is not very much. That is one side in the financial incentives of taking on responsibility and recognising the qualifications. Then there is another side that I think is perhaps even more important to our members, which is the day-to-day recognition of psychology skills. We see at the moment, due to the overwhelming demand and due to the case load that they are seeing, that there appears to be a very large skewing towards case management and risk management. They are activities that could be done by someone else who does not have a psychology degree—maybe has a masters or is doctorate trained—and then more of an emphasis could be put on recovery, treatment and really utilising those psychology skills.

CHAIR: Your submission refers to parental education programs to prevent anxiety disorders in children. How would they be rolled out? Could they be incorporated on a broader parenting type program?

Dr De George-Walker: Yes. We would be looking at working that up into a more detailed proposal. We would be looking at what would be the best way to roll those out. Including those in existing structures and as part of existing kids' and parents' hubs is one way it do that, absolutely. I guess that is an idea we have that we are really keen to work up with partners to meet the needs, in this case, of Queenslanders. Each state obviously has different systems and structures that we could hook into, so we would be looking particularly at what we would do there.

CHAIR: Is the reason that you are keen to go down that path related to the fact that that would have a preventive value in terms of preventing anxiety disorders and anxiety related disorders later in life for kids?

Dr De George-Walker: Absolutely. We know that the earlier we intervene, we will have downstream effects of mental health rather than mental illness. With children and infants, parents are absolutely key in their world. The more that we support parents to be healthy, happy and well, the more they in turn can support their children. It is targeting parents particularly in that perinatal and infancy period, very much so.

Dr Murray: If I may say something there—and please correct me if I am wrong, Linda—from memory, the Productivity Commission identified that as one of the ways we could have a really high return on investment. Investing in those types of programs will really see a large impact.

Mr O'ROURKE: My question is around some of the difficulties in trying to recruit staff into regional, rural and remote Queensland. Throughout these hearings, we have heard about incentives such as housing being supplied, pay packets and all of that sort of thing. Is there a really practical and simple way of getting people out there that we are not doing?

Dr Murray: I absolutely agree with what you have already heard. I guess we could go through a number of different initiatives, but something that could certainly be instigated straight away would be for Queensland Health to really incentivise placements in regional and remote areas. That would mean supporting staff who come for placement and it would also incur costs around supporting people who go to those placements. Even if there is a cycle where people go for six months or so and then come back to metropolitan areas, at least there will be another person coming through. The more exposure that people have to those rural and remote areas, the more likely they are going to stay, build a life and so on. There is something that has to be done to break that cycle and that is with incentives. Through the public sector, having a really strong program—the APS would be very happy to partner with government to coordinate that. That could be available tomorrow.

CHAIR: I would like to thank you for presenting this afternoon. Certainly your submission was good and your presentation will help us form the recommendations in our report. Thank you very much for your time.

Dr De George-Walker: Thank you for the opportunity and all the best to the committee for your work.

Proceedings suspended from 1.09 pm to 1.47 pm.

COX, Ms Katrina, Member, Queensland Nurses and Midwives' Union

DAWBER, Mr Chris, Member, Queensland Nurses and Midwives' Union

LEE, Ms Julie, Research and Policy Officer, Queensland Nurses and Midwives' Union

MOHLE, Ms Beth, Union Secretary, Queensland Nurses and Midwives' Union

CHAIR: We will now reconvene the public hearing for the Queensland parliament's mental health inquiry. I welcome representatives of the Queensland Nurses and Midwives' Union: Union Secretary, Beth Mohle; Research and Policy Officer, Julie Lee; Katrina Cox, member; and Chris Dawber, member. I should put on record my membership of the Queensland Nurses and Midwives' Union. It has been 34 years, I think, and it is on my public register. I ask you to make a brief opening statement and then we will go to questions.

Ms Mohle: The Queensland Nurses and Midwives' Union thanks the committee for the opportunity to comment on this very important inquiry. As you know, my name is Beth Mohle and with me today is Julie Lee, Katrina Cox and Chris Dawber. The QNMU represents the industrial and professional interests of our members of over 65,000 nurses and midwives who provide health services across Queensland. They work in a variety of settings from single-person operations to large health and non-health institutions in the public and private health systems. We have members working across mental health services including hospital based services, community services, non-profit organisations, primary health and corrections. Mental health nurses are the largest occupational group within the mental health workforce and also make up the bulk of hospital based mental health care and prison mental health services. There are approximately 4,600 mental health nurses working in Queensland today.

Today I will speak on the needs of the mental health system in Queensland and the opportunities to improve mental health outcomes with a focus on the mental health workforce—specifically, how we can support and grow the mental health workforce and what some of the current barriers are. There is a pressing need for a robust and sustainable mental health workforce in Queensland. Hospital wards are routinely understaffed in part due to inconsistent models of care where in some instances team leaders carry a patient load. Far too often the minimum legislative ratios become the actual ratios rather than the notional ratios that are required to be determined under the business planning framework.

Inadequate skill mix is also of concern. Community mental health nurses report untenable workloads, and residents of rural and remote areas struggle to receive timely mental health treatment due to lack of services. Not only is this an issue of safety but also an issue of the capacity of the mental health services in Queensland to deliver high-quality treatment and outcomes. Inadequate nursing staff numbers is also a contributing factor to workloads above the legislated nurse ratios, high levels of reported staff burnout, increased intention to leave the profession and subsequent loss of clinical expertise.

Currently the Nursing and Midwifery Board of Australia does not recognise mental health as a specialty. While it is possible to become a credentialed mental health nurse, this accreditation does not provide special autonomy, scope, regulatory recognition or entitlement such as a Medicare provider number. There is no recognition of the specialist training, skills and knowledge required to become and practice as a mental health nurse, which diminishes the ability of mental health nurses to advocate for their clients and adds to the public perception of mental health nursing. This further adds to the stigma of mental health in Australia. It is another reason why senior experienced mental health nurses are leaving the profession altogether. The QNMU believes that reinstating the endorsement for nurses with a mental health qualification is the first step in supporting and growing the mental health nursing workforce.

In our submission we outline several opportunities to boost the mental health nursing workforce. I will highlight two of those today: firstly, increasing the accessibility to mental health nursing pathways through scholarships, subsidies or financial incentives. The cost of obtaining a specialist qualification in mental health can be a significant barrier to pursuing further education. Not only is the degree expensive but it requires time for study that otherwise could be spent on earning an income. There are few avenues of financial assistance in Queensland. However, our members have told us that there is a demand for it. As highlighted in our submission, the Victorian government offers 100 scholarships every year to assist nurses to achieve a mental health qualification. There must be an ongoing year-on-year investment by the state government to train mental health nurses, especially for regional, rural and remote areas where recruitment is a real issue.

Another opportunity is to strengthen the role and function of nursing-led models of care in mental health; for example, employing more mental health nurse practitioners and nurse navigators. Nurse practitioners are experienced registered nurses who are educated to a master's level and are competent to function autonomously and collaboratively in an expanded clinical position. Nurse navigators work with individuals who face additional barriers to accessing health services through coordinating care, forging partnerships and facilitating system improvement.

Nurse practitioners and nurse navigator models have been successfully implemented in emergency departments, community mental health services, alcohol and other drug services and in primary health. Despite the success of nurse practitioner and nurse navigator models of care and the benefits they provide to the healthcare system, they remain unfortunately too few and far between. Nurse practitioners and nurse navigators need to be fully embedded into the healthcare system as a viable and effective avenue for mental health services by promoting models of care that employ these roles and enabling these roles to work to their full scope of practice.

We understand that more can be done to improve mental health outcomes and addressing workforce issues. However, we believe it should be a key focus. Without a mental health workforce there would be no mental health system. Again, thank you for the opportunity to present to the committee. I will now hand over to Katrina, who will be followed by Chris.

Ms Cox: I started my nursing career in New Zealand. In 1999 I moved my family to Australia. I started working in acute and community settings, and 17 years ago I decided to transfer to mental health as I wanted to follow people's journey and work with them in their recovery. In my time as a mental health nurse I have gained my postgraduate master's degree, trained and facilitated talking therapy, and maintained my credentialing as a credentialed mental health nurse. I have worked in an inpatient setting, community setting, as a nurse navigator and now for a not-for-profit organisation supporting military, first responders and corrections officers suffering from PTSD.

I came into nursing to make a difference, to help give people back some quality of life. To me, part of this is maintaining a good evidence based education and skilled workforce. In this current climate we do not have enough psychologists, social workers or mental health staff to provide the care that people require. This does not have to be the case as many mental health nurses are trained in delivering individual therapy, group therapy and other interventions to the community.

As we all know, medication has a place in recovery but so do other interventions like talking therapy. Under the current Medicare scheme, credentialed mental health nurses can bill, but there are limitations to this. We cannot bill for delivering talking therapy to people who need it in a community that is overrun by mental health issues with limited psychologists and social workers to cater to the need. Instead we turn people away and we lose them to taking their own lives. We have a chance to change this. Let's not lose more people. Let's work together and deliver the services that we are trained and dedicated to do to support people to live a long and happy life.

Currently mental health nurses make up over half of the qualified mental health staff in Australia, but we are a dying breed because we are not recognised for the qualifications, experience and training that we have or are undertaking. When I first came to Australia, nurses were regulated by this state and the mental health nurses and midwives were recognised. Then we went to national regulation and midwives kept their recognition but mental health nurses lost theirs. It is time to recognise the dedication, commitment and specialised quality of service that mental health nurses deliver and contribute to this country by recognising their commitment and service to this great country. We do this by endorsing their qualifications and appointing a chief mental health nurse who works for mental health nurses.

Currently we have a Chief Nursing and Midwifery Officer and they do an amazing job, but they do not have sufficient mental health expertise, so they cannot fight and deliver the voice that mental health nurses require. Please look around and see the people here before you and know that we all have an agenda to deliver and support people with mental illness, but currently we do not have the recognised workforce to make the difference that this country and citizens need.

Mr Dawber: I am a mental health clinical nurse consultant. I have been working in the public sector for nearly 40 years now. I also have a small private practice and I provide clinical supervision and psychotherapy to nurses, midwives, doctors and allied health professionals. I am drawing my statement from my experience in both of these fields.

As the largest clinical workforce in the health system, I think that nurses provide the bulk of the interpersonal aspects of caregiving and with that comes a burden of emotional labour. I think this is particularly true in the field of mental health nursing where the therapeutic use of self and the ability

of a nurse to manage the milieu or the environment are really key clinical tools. I am concerned, as the other speakers today are, that the specialty of mental health nursing has been eroded over past decades and we are now under threat as a profession.

I do not believe that undergraduate nurses are provided with a depth of training required to develop the therapeutic and interpersonal skills that are required for this role. I also worry that those nurses who do have skills, like Katrina, in the public sector are not often given the opportunity to exercise them. Instead, nurses are required to focus on a growing number of tasks—many of them administrative—that keep them from spending meaningful time with their patients.

There have been a number of studies into consumer perspectives on mental health nursing. Some of the findings are that, whilst our consumers view us as multifaceted, practical, social and psychological support givers, they also see inpatient mental health nurses as particularly inaccessible, and that is because they see them as being so busy.

Mental health nurses in inpatient settings who provide supervision and group supervision to many of these would agree with this, and they feel they have very limited opportunities to work meaningfully with their consumers; they really regret this. In my experience, these mental health nurses desire to be able to create a therapeutic environment and to work collaboratively with consumers, but they find it difficult to get the time amongst all their other tasks.

We do not want to follow the example of the UK where one study of mental health consumers found that, per shift, they only get to spend up to 20 minutes of time with their nurse in an eight-hour shift. Reciprocally, it is these interpersonal aspects of mental health nursing that provide us as nurses with our greatest compassion satisfaction, and this is a key element in professional quality of life. Whilst there needs to be a focus on efficiency, economic rationalism and the business of health care, my concern is that this has come at the expense of quality of care for our mental health consumers and job satisfaction for the nurses who deliver that care.

The other elements of professional quality of life are burnout and secondary traumatic stress. There is the positive emotion, compassion satisfaction, which you get from meaningfully interacting with another human being and helping them; then there is burnout and secondary traumatic stress, which are exacerbated by factors such as high workloads and lack of support. I believe that if the professional quality of life of nurses is not addressed, more will end up leaving the profession and not just in mental health nursing.

On current modelling, the ABS is predicting a shortfall of over 120,000 nurses in Australia by 2030, 18,500 of those being mental health nurses. I really believe we need to start exploring ways of reforming clinical practice for mental health nurses, adopting a more client focused, clinically driven approach, rather than increasing governance and accountability measures that ultimately take mental health nurses away from direct patient care.

I want to qualify this. In the next statement I want to talk a bit about the disconnect between managerial and clinical agendas, but I want to make it clear that I am not criticising individual nurse managers whom I know personally and many of them feel this tension as well. In the Forster report 2005, in its systems review, there was a clear statement about the culture in Queensland Health at that time being one that demonstrated disconnect between these agendas, and I think this is still the case. I believe that when nurses feel invalidated, under-resourced and unable to achieve the level of care they aspire to, this affects the consumers they are dealing with. This can lead to incidents of frustration and sometimes aggression, and I think that nurses are generally the ones who bear the brunt of this as well. I think greater measures need to be taken to ensure nurses' safety, as well as to ensure the provision of regular supervision and support to help them deal with these types of situations. I do not think this has always been the case.

In the past, the QNMU and the Queensland state government have worked hard to establish nurse-patient ratios. I believe that in mental health nursing in particular, these ratios should be revisited to reflect the important interpersonal aspects of caregiving that I have outlined earlier. We need to make more time for patient contact. We need the skills to provide therapeutic interventions. It is better to spend a little more time with a distressed consumer in the early stages of a crisis than to allow that crisis to worsen due to a perceived lack of validation, a sense of isolation and growing frustration.

Just as proactivity is the key in clinical practice, it should also be the key in service planning, and this Mental Health Select Committee inquiry provides an opportunity for us to do something proactive. My key point is that I believe we need to revise and streamline the growing raft of tasks and administrative requirements that inhibit our mental health nurses in their ability to attend to and to provide therapeutic interventions for patients. I think we urgently need to regain a focus on quality

of care, upskilling the mental health nursing workforce and providing them with greater opportunities to provide therapeutically and clinically. We need to encourage and reward professional development through scholarships, grants and competency-based skills training. We need to not only support the inclusion of more mental health options in undergraduate training but also develop advance practice nursing options such as nurse practitioners. We need to have more active acknowledgement and support of the specialised nature of this particular branch of nursing through accreditation, endorsement and credentialing, and we also need suitably qualified and experienced mental health nurses in other roles through the primary care sector and the non-government sector. If nurses are our largest workforce and the ones who work most closely with mentally ill consumers, it makes sense to support them professionally and personally to maintain and develop this quality of care.

CHAIR: For the sake of clarity, to become a mental health nurse at the moment and be employed in Queensland Health or a private hospital, you do not technically need to have a mental health qualification; is that correct?

Mr Dawber: That is correct.

CHAIR: However, if you did want to become a qualified mental health nurse and you were a registered nurse with a degree of qualification, would you have to go back and do an additional degree or is it just an add-on?

Ms Lee: Additional.

CHAIR: So another four years of training?

Ms Lee: Not four years. It is a graduate diploma.

Ms Cox: You can do a graduate diploma or you can do a master's degree. If you do a graduate diploma, it is not as long. A master's degree is about three years.

Mr Dawber: That is to become credentialed with the College of Mental Health Nurses. That is not a requirement to work in mental health or to call yourself a—

Ms Cox: It used to be; that is the thing. When I did my master's degree, when I worked in community, you could not be a clinical nurse working in community without a master's degree or obtaining a master's degree. That has changed now.

CHAIR: That has all changed since Ahpra was introduced?

Ms Cox: Yes.

Ms Mohle: Some jurisdictions do have that requirement. I am aware that South Australia does have that requirement where you do need to have a mental health qualification, but not every jurisdiction has that requirement.

CHAIR: The submission talks about the need for scholarships to encourage nurses and midwives to obtain mental health qualifications. Is the thinking there that we need more nurses and midwives working in mental health settings, or is it also to get more generalist trained nurses and midwives skilled up in terms of responding to people's mental health needs in their regular practice?

Ms Mohle: I think it is probably both. Both are required. In Victoria, as we highlighted in our submission, for some years now they have provided scholarships to pay for, I think, half the cost of the graduate diploma. That has been oversubscribed every year in terms of the interest from nurses to gain that qualification, but we do require a focus on both.

Mr Dawber: I work in a consultation liaison service, so I work providing mental health specialist services into the inpatient general hospital units. Anyone who is admitted to a general hospital will have some sort of mental health issues—stress, anxiety. There is a lot that nurses and midwives can do in that space. Giving them support and training is an important component. There is that part of it, but I also think that in the mental health specialist area we need more developed skills and training.

CHAIR: It was interesting to read your submission and recommendations around the need for midwives to have mental health training. I have to admit it is not something I have necessarily thought of before. We have heard a lot about the need to improve perinatal mental health services. This would play a role in that aspect of care?

Ms Cox: The number of mums who have postnatal depression or develop post-partum psychosis is amazing. Midwives are not trained and they will say, 'We are not trained to deal with mental health.'

CHAIR: From a clinical perspective, Katrina, many women—sadly, not all, but many—will see a midwife for a period of time before the birth, hopefully at least 12 months, on a regular basis. I guess there is an opportunity there. Are there interventions and things that can be done to minimise the risk of postnatal depression and psychosis?

Ms Cox: There is and there isn't. A lot of it is family history—that plays a huge part—and also what is going on environmentally in their household. Mental health is a specialised area. We look at someone and we read them; that is what we are trained to do. We know when someone is interested. We know when someone is not doing too well. It is hard to train someone for those skills because they are things that we learn as we develop. However, we can train midwives and nurses to recognise those things.

My daughter-in-law is hopefully having her baby tomorrow. I have been to her midwife appointments with her, and they do not look for that. It is very tick and flick. The doctor sits there and goes, 'So, have you had this? Have you had that? Have you had that?' and does not make any eye contact with her at all. So how do you actually find out? Is she just answering the question? Is she just saying, 'Oh, yeah, I'm fine,' or 'No, I'm not'? We do not do that as mental health nurses. We delve further into things. We ask them questions. We have talks with them so we can gain the correct responses.

Mr Dawber: Can I just add something to that? Yesterday I ran a mindful mums group; it is one I have been running for five years. I work with pregnant women, ironically as a middle-aged bloke. It is one of the highlights of my working week. We have gone online because of COVID, which creates extra challenges, but a midwife and I developed this. The midwife had an interest in yoga and mindfulness practice so we run a succession mindful mums group. You do not have to have a mental illness to come to that. It is a preventive, proactive measure.

Remember in my statement I was saying how proactivity is so important. This is where midwives and nurses with mental health experience and training can make a difference because you can prevent things developing into postnatal depression. Perinatal anxiety is much more common. Anxiety is something that is part of life. We try to help people develop skills and resilience. I think this is really important because it speaks to this duality that we need more mental health included in generalist training, but we also need more specialist training for those who deal with—I do not want to use the words 'worst of the worse', but more severe.

Mr MOLHOEK: Chris, you touched on the issue of—I think your words were—the growing raft of administrative tasks. The other day when we were in Hervey Bay, I was speaking with a few nurses who said that they are all becoming 'computer nurses'. I asked the question just casually, 'How much time do you spend with patients and how much time on the computer?' They said, 'Oh, it is quite a bit.' I said, 'Would it be 40/60?' They replied, 'Oh no, it's more like 80/20. We spend 80 per cent of our time ticking boxes and filling in forms around risk compliance and all sorts of data collection that the department wants, and we are only spending 20 per cent of our time with patients.' Part of what we need to be doing is looking at ways that we can better service the people of Queensland. Do we need to strip some of the red tape and some of the risk aversion out of the system so that we have more time for nurses to work with patients?

Mr Dawber: Thank you, Deputy Chair, I agree wholeheartedly. I think you have hit the nail on the head. This is something that I find universally. Remember, I work in a particular health service but I also work across multiple health services. I provide consultancy into different health services. This is universally what nurses are saying, particularly in mental health. I wrote an article for *The Queensland Nurse* in 2015 and I have cited it here. It is called *INCAPACITATED by bureaucrac*y: *A mental health nurse's perspective on the Australian mental health care crisis*. What I think is happening is that we are now so tied up in accountability measures and ways of accounting for what we are doing that we no longer have the time to do them. I think that we really need to seriously look at least at rationalising and streamlining these things. They are necessary—we need to ensure accountability—but we have gone so far to that extreme now that it is inhibiting our clinical practice.

Mr MOLHOEK: Can we get a copy of that article, please?

Mr Dawber: Yes, of course. I will send it.

Mrs McMAHON: I am going to ask a couple of questions which will probably very much highlight my ignorance of the nursing profession. You have given us the numbers of how many nurses we have in Queensland and how many mental health nurses there are. How many universities in Queensland are offering the undergraduate nursing degree or qualification?

Ms Mohle: About six or eight of them, I think. I will count down the coast in terms of the number.

Mrs McMAHON: So pretty much all of the major universities are offering an undergraduate degree in nursing?

Ms Mohle: Yes.

Mrs McMAHON: How many are offering a postgraduate, whether a graduate diploma or master's in mental health?

Ms Mohle: I know that UQ does. We will get back to you on that in terms of the actual numbers.

Mrs McMAHON: I am just trying to get an idea of the training continuum and these blockages. With these undergraduate degrees in nursing, is it a general nursing degree or do some of the universities potentially offer an undergraduate degree that has a specialisation in a type of nursing?

Ms Cox: It is mainly nursing degree and for mental health they get four weeks.

Mrs McMAHON: There is a bit of a subject here that touches on it.

Ms Cox: Yes.

Mrs McMAHON: A Queenslander graduating with a nursing degree and who goes to work either in the public or the private health system will have only had a very light touch on mental health training yet still can go and work as a mental health nurse. Do you see the potential for a nursing degree that has an ability to specialise? I know with psychology degrees you can do an undergraduate degree which focuses on research, or you can do an undergraduate degree that focuses on counselling. Given the number of universities that we have offering undergraduate degrees, given the need we have for properly trained mental health nurses, is there a role for an undergraduate nursing qualification that does have a focus or a specialisation in mental health?

Ms Mohle: There is direct entry midwifery now, for example. They are separate professions, nursing and midwifery, and you can do dual degrees. I certainly think that that is something that requires further exploration as a matter of urgency. This is a specialty that is in significant demand in terms of skills. We already have had skills shortages in mental health before the pandemic. I have to say, now that we have had the pandemic, I am fearful about how we are going to deal with the aftermath of all of the mental health implications arising from the pandemic. We need to focus on that as a matter of urgency in terms of what further educational preparation and what further different courses are needed to cope with the demand.

Mrs McMAHON: Obviously the postgraduate training is a lot more select. I understand you finish your nursing degree, you want to get out there and work and earn money, and the idea of then going back to do further studies for some people is often quite prohibitive if we want to say that you need to be accredited to work in the space. How can we make it more accessible to an undergraduate to get that kind of qualification?

Ms Mohle: That is why Victoria went down the road of scholarships. As I said, the Victorian government offers 100 per year that is, as I said, oversubscribed. From memory, I think it is half the cost of the graduate diploma that they meet for those every year, and that has been going for the last four or five years, I believe.

Mr Dawber: I know at one stage Victoria was also looking at undergraduate mental health nursing training, and I think there is some merit in that. That is a personal opinion, not necessarily a union opinion. I think there is possibly a role for specialised undergraduate mental health training.

Ms Cox: It was not in all districts, but in parts of Brisbane they used to have specialised training that was run through the Park. They would train mental health nurses and it was very specialised. You obtained a certificate at the end to say that you had done it and you went through all the different community settings and inpatient settings, therapy—everything—but I do not know if that still runs.

Mrs McMAHON: We have been talking to a lot of people about peer workforce. Do you see a role within the mental health nursing career pathways of having a peer workforce as a certain percentage or component of your mental health nurses—that is, those with lived experience?

Mr Dawber: Yes. I formed that opinion from several things. One is my own lived experience with mental health issues. Another is through my daughter who is a mental health peer support worker. Many of us have our own lived experience with mental health issues. We are all peers. Identifying that, explicating that and seeing that as an important part of development is important.

Mrs McMAHON: Some of the conversations we have had with some of the groups already today are about identifying or getting someone who is prepared to put their hand up within a profession to say that they have lived experience in order for them to tick the peer workforce. We have had a submission that 10 per cent of the Queensland mental health workforce should be a peer workforce. Given that the mental health nurse makes up a significant proportion of our mental health workforce, that would have implications for your nurses. The stigma of putting your hand up—

Ms Cox: But I think that that is already the case anyway because how do you define what is mental illness? People have anxiety. I had anxiety reading out that thing, but that is under the banner of mental illness. If you look at the DSM-5, that is part of mental illness. If everyone here today looked at what our traits are and looked at our DSM-5 or our ICD-10, we would all tick some sort of mental illness. It is how severe that mental illness is. We are all impacted; we all have lived experience.

Ms Mohle: The point is you can build a career path for the peer workforce. They could be supported to gain enrolled nurse qualifications and then articulate to registered nurse qualifications. We should be looking at this as a journey. You can bring peer workers in who have not got qualifications and support them to gain qualifications. That is how we should be looking at this, I think.

CHAIR: Thank you for that. I think every member of parliament would tick the 'oppositional defiant disorder' box. With that, I will go to the deputy chair.

Mr MOLHOEK: You were talking about the different pathways. I would have thought that most nurses, like most normal non-nurses, would want to change their careers and their focus multiple times. We hear stories of people changing their career on average five times in a lifetime. It seems to me that if you want to train to be a mental health nurse and it takes four years to get a diploma or graduate degree, you might do that for 10 years and think, 'I do not want to do this anymore. I just want to do ICU or I want to be a midwife or I am going to become a nurse practitioner and patch people up in a clinic or something.' Are the pathways too onerous? Are the demands of the training too much that people cannot have a bit more variety in their careers?

Ms Mohle: Health care has become more specialised in recent years so it is a bit more difficult. Once upon a time there probably was a bit more movement, but now people tend to go down a particular path. Some might want to have a bit of a change, say, between emergency department and critical care, but it tends to be within the same domain. We should be making it easier for people who do want to move to other areas to do so and have articulation to different courses to require them to do that.

Mr Dawber: It is not necessarily either/or. It is both of those things. Some people may be very clear and want to do mental health nursing in the beginning, like I did, with no desire to change, but it is good to have the option to do so.

Mr MOLHOEK: If you feel trapped that would create mental health issues in itself, would it not?

Dr ROWAN: Before I get to my question, I want to clarify, following on from the question of the member for Macalister and your recommendation on page 9 of the Queensland Nurses and Midwives' Union recommendation around the Queensland government introduced ongoing scholarship and financial incentive schemes to support specific training with the mental health qualification, that I think in Victoria there were 100 places?

Ms Mohle: That is my understanding, yes.

Dr ROWAN: What would your recommendation be as to how many places there should be in Queensland? Is there any idea of the quantum of money that you would require?

Ms Mohle: We can provide the information on the Victorian scheme very easily; I do not have that with me right now. However, we would be looking to, and we quite often point to, the Victorian experience and how successful that has been. We think it would be very good to replicate that sort of scheme in Queensland.

Dr ROWAN: Can that be taken on notice, just how many places and how much we would need? That would be really helpful.

CHAIR: To clarify, I think the member for Moggill is seeking the number you would recommend here in Queensland.

Dr ROWAN: And a quantum of money, approximately; that would be helpful.

Ms Mohle: Yes.

Dr ROWAN: Coming to my question, in relation to nurse practitioners and the current award structure that is here in Queensland to incentivise to recruit and retain people, is there anything that needs to happen in relation to the award structure for the recruitment or the retention of bringing people into the area?

Ms Mohle: No, there is nothing. There are no industrial barriers to this at all. It is having the will to grow the workforce that can work to an expanded scale. Queensland should be proud. We have the highest number of nurse practitioners in the country, actually; it is just that it is simply not enough to meet the demand for those services, so we need to be investing there. Similarly, in Queensland we have 400 nurse navigators who have been phenomenal in terms of the difference they make to people with chronic and complex conditions. We need many more of those as well. We are the only jurisdiction that has that particular role. That is only in Queensland. We just need more of them because the system needs to be focusing much more on community-based, non-acute care and keeping people well and out of hospital, and those sorts of roles are really critical to delivering that outcome.

Dr ROWAN: Mr Dawber, with that reference to the Forster report back in 2005—and we know the circumstances around the Bundaberg Hospital commission of inquiry back then—I know you were very careful with your words, but in regard to that bit of disconnect between managers and clinicians and what drives that, is there anything that can be done to reduce that so that it is a shared sense of purpose? Are there things in the system which lead to a bit of disconnect between the shared outcomes? I am sure our clinical nurse managers, all of our people in management roles, all want the same things that the clinicians want for patients?

Mr Dawber: That was the point I was trying to make by putting that little caveat in there. I think it is really important. It is difficult. I do not have the answer to that because it is such a complex question. The point I was trying to make is that that focus has become the dominant paradigm. I think we just need to consider more. The point I was making was that the clinical needs of mental health consumers require time, and that time and quality of interaction with mental health nurses is hard to achieve when the other agenda of throughput and expediency is the thing that is focused on most. There is a principle there and that is that I think we need to reclaim some of that clinical focus into those decision-making processes. I do not know how we would do that. I have not really come up with a solution, but I think a start would be to begin understanding that mental health nursing can take quite a lot of time. It is not about going in and changing a dressing. I would be prepared to spend one or two hours with a client in order to de-escalate a crisis situation, which may then end up with them requiring seclusion and two or three days worth of quite invasive treatment. The 'stitch in time saves nine' adage really applies here. I think that we look at saying you need more time, therefore we need to focus on the quality of care, and the way that we make decisions on a corporate level or on an organisational level need to reflect that.

Ms Mohle: Following on from what Chris said—we could spend all afternoon speaking about this topic—the *Unleashing the potential* report that was released recently about the experience in COVID demonstrated that, really, if you just get out of the way of clinicians and just let them work to their full scope and do what they are able to do, so much more would be done. That would cut away a lot of the red tape. It is removing the barriers, enabling them to do their job. I would just like to say that people trust nurses and midwives with their lives on a shift-by-shift basis, but they are not trusted with the budget. There is something skew-whiff in the system in terms of what the trust is about. We need to refocus the system. Maintaining budget integrity is important, but it is a balancing act. It has to be balanced with clinical outcomes, facilitating people and enabling clinicians within the system to get on and do their job.

Mr O'ROURKE: Throughout the hearings we have heard a lot around strengthening and expanding the community-based mental health service. I notice in your submission you talk a bit about expanding the co-responder program where emergency services, police and ambulance, also have mental health nurses involved in that process. How would that work practically on the ground?

Ms Cox: It works now.

Ms Mohle: It is already working now.

Ms Cox: We have mental health clinicians who ride alongside police and ambos, and it works well.

Ms KING: I think the member is more interested to know how we can roll it out everywhere else.

Mr O'ROURKE: That is right. I am pretty sure I do not have that in Rocky.

Ms Mohle: Again I think this is where there is an inconsistency across hospital and health services. There have been trials at the Gold Coast Hospital and Health Service and other hospital and health services that have proved to have really fantastic outcomes in terms of keeping people away from hospital. The system just has to work out ways to replicate what is working really well and to make sure that it is rolled out across the system and not just in pockets of excellence.

Ms Cox: I think the hard thing is that the further west you go the harder that is. They are the ones who need it. They do not have the services available to them. I have worked out west. I managed one of the services out there for a long time. You work really closely with your police, fireys and ambos, but you do not have enough trained clinicians who can go out with them. That makes it hard so then who becomes it? The fireys, the ambos and the police! It makes their job 100 times harder.

Ms KING: Thank you all for being here and for your consistent advocacy for better health care, more nurses and better systems for nurses every time I am here in one of these inquiries. Thank you so much. I will follow on briefly from Barry's question and note that we received feedback on that point. It is harder to deliver a co-responder model as you go further into regional areas and the

exigencies of scale become problematic. I want to ask about stigma. In the course of this committee we have heard a lot from consumers and practitioners about various kinds of stigma. Is there stigma involved in being a mental health nurse?

Ms Cox: I was a general nurse before I was a mental health nurse. I was joking with Julie on the way here, saying, 'I remember having conversations that mental health nurses have to be as mad as their patients to be mental health nurses.' Yes, there is a stigma, and it is not because people are nasty: it is because they do not understand mental health. General nursing is their speciality. People fear what they do not know. Because they do not know mental health and they are not trained—like I say, they have four weeks placement for mental health nursing in their three- or four-year degree—that is not enough so they get fearful. When you are out west and you are the mental health nurse when you are in general, that makes it even more fearful. Then they overmedicate because they think that helps contain it, but it actually makes the problem worse.

Mr Dawber: I think mental health nurses actually play a big part in overcoming that stigma not only by advocating for their patients but also by working with their colleagues and helping to address some of the ignorance and educate and promote mental health awareness.

Ms Cox: When the government introduced SRAM-ED, which was suicide prevention in the ED department—and I was the trainers' trainer for that—that actually helped break down some of that because we taught ED staff and ED nurses how to respond to people when they came into the ED. They are their first port of call. Some nurses would sit there and look at their paperwork and not make any eye contact, which had a really negative impact. I think that made a difference, because they got training to know how to respond to people when they came in with mental illness.

Mr Dawber: There is also this kind of stigma or compartmentalisation in other areas of nursing and other areas of medicine. There is this idea that we can focus on our differences, but I think that once we enter into a dialogue and have communication, whether it is in the broader community or in the nursing workforce, then we start to break down that stigma.

CHAIR: The submission talks about the need to reform the mental health funding allocation in primary health to directly fund point-of-care services. Would you be able to expand on that and how that might assist with dealing with what we call the missing middle?

Ms Mohle: I think we need to fundamentally focus on community based services and offering new types of services, multidisciplinary or even nurse-led services within the community. We need to be keeping people away from acute-care facilities that just are not good for people who are acutely unwell. They need to be cared for as close to home as possible. I think we need to reframe the way we think about the delivery of not only mental health services but all health services. That is going to take some time to do, as we know, because systems are slow to turn, but that is what the QNMU firmly believes. We need to be fundamentally looking at our models of care and moving much more to community based models of care. Katrina or Chris may want to add to that.

Ms Cox: I spoke about Medicare. As a credentialed mental health nurse—and I work in a not-for-profit organisation—I can bill Medicare, but only to do assessments and blood pressures and stuff. I cannot bill them for the talking therapy that I have extensively trained in. Some psychologists have not had some of my training. I can deliver it—and I do deliver it now with psychologists—but I cannot bulk-bill for that. I cannot take it on there. People come to me and say, 'Why can't we just come to you for therapy?' They can, but then they would have to pay. I do not want to charge them an arm and a leg to come and see me to provide therapy so they can go off and have quality of life.

Ms Mohle: There are funding barriers, there are policy barriers and there are cultural barriers to making sure we deliver services in a way that—

CHAIR: I am not sure if you are familiar with the submission by the Queensland Alliance for Mental Health, but they seem to propose a very similar model: moving away from acute-care services or at least increasing other alternatives. There is another area I wanted you to comment on because I do not think you touched on it in your submission. I am particularly interested in your thoughts around mental health services for people who live in aged care: whether there is any, what the scenario is and whether we need to do more in that space.

Ms Mohle: There are very limited services available to people who live in aged care. Unfortunately, the shame is that our health and aged-care systems are not joined up right now. I personally believe that it is a denial of people's right to access health care in residential aged care because they are essentially being denied access to the services they need. We have a fragmented system that is not joined up, and again it is our funding models. The federal government funds aged care and the state government largely funds and runs public services, and there is a difference as well. There is primary health care and the federal government has a large funding input there. The

systems just are not joined up. That has really bad outcomes for people, particularly very vulnerable people like those in aged care. I do not know if Chris or Katrina would like to add anything, but it is a disgrace what is happening in aged care. People are being effectively denied care because the system just is not working for them.

Ms Cox: When I managed a service out west, we used to go to aged-care homes and provide service, but you just do not have the staff. You do not have the staff in community mental health to man the community as well as the aged-care sector. Unfortunately, they get missed out and that is really sad.

CHAIR: I know this has been well-ventilated through the aged care royal commission, and you have no doubt made extensive submissions there either directly or through your federal body. Would it be related to the fact that, maybe not intentionally, the reality is that for many people aged care is viewed as a place where you go to deteriorate and the deterioration of your situation is not only expected but is acceptable?

Ms Mohle: Going into aged care is not a choice. People do not choose to go into a residential aged-care facility. That is what makes what is happening in aged care even more disgraceful. The fact is that people want to stay at home for as long as they can. Once you do get into a residential aged-care facility, unfortunately, it is the case that the length of stay is not very long. You need more intensive nursing at that time. Currently what we have is a situation where there is this total inadequacy of nursing in aged care, and that is what the royal commission highlighted. It does fall back, unfortunately, to the public system quite often to do the outreach and go in and fix problems when it does get to a crisis point.

Ms Cox: When you have someone in aged care, they have lost their identity so their mental health is already really low. It has declined because they used to be—and they still are—a father, they used to be a farmer, they used to work, they used to provide, they used to live in their own home. All of a sudden all of that is gone, and they live in a room and that is it. They get told what they have to do and what they cannot do. Their whole life changes and their mental health declines. They are probably one of the cohort of people who are very depressed and they have severe mental health. But because of their age and because they live in residential care, people think they are being looked after because there are already staff doing that, but those staff are not trained in looking after people with mental health.

Ms Mohle: Guilt is an incredible silencer of the system. Families feel guilty because their loved ones are in residential aged care and the staff, who do the best that they can under really terrible circumstances, feel guilty that they cannot deliver the best possible care. Unfortunately, guilt puts a lid on having this talked about more and being dealt with.

Mr Dawber: I think this is another situation where this combination approach of providing more mental health training to basic healthcare staff and nurses but also having the capacity of psychotherapeutically trained nurses providing consultation and liaison into those services could help address the problem.

CHAIR: I will go to the member for Moggill for a final question.

Dr ROWAN: On page 10 there is a recommendation to appoint a chief mental health nurse in Queensland. I accept the basis of that and the benefits. I imagine that would work alongside the Chief Psychiatrist. I guess my question is around governance. In Queensland we have the Chief Health Officer, Chief Medical Officer, Deputy Chief Medical Officer, Chief Nursing Officer, Chief Allied Health Officer and Chief Aboriginal and Torres Strait Islander Health Officer. How do all of these people interact to try to bring that all together, given what I would say is a number of people with cross roles, when we are trying to talk about getting good mental health policy in place, and it certainly cuts across that? How do you bring all of that together?

Ms Mohle: They should certainly be working collaboratively. It does actually go back to the challenge that was thrown out by the Forster inquiry; that is, we should have invested a lot more time in working out the cultural issues in health that we have been avoiding dealing with for a very long time and dealing with power and relationships within health care. That would go a long way to sorting that out.

At its heart it is about collaboration. Elevating mental health nursing to be the speciality that it is requires a chief mental health nurse to give it that amount of emphasis and visibility within the system and recognition of the expertise of mental health nurses. It is a challenging thing and there are a lot of chiefs—I take your point. But it is really important to have that within the system so there is a diversity of voices and opinions and they are heard, to deliver together the best outcomes we can.

Dr ROWAN: I guess my question is: does there need to be some sort of governance committee or structure that they all sit on?

Ms Mohle: Absolutely there needs to be strong governance around this and appropriate governance networks that are taught to work through that in terms of who does what. It does need to be framed in terms that we are collaborators and equals, and sharing power needs to be at the heart of that. The person who is most often the most disempowered in health care is the person receiving the care. I hate the term 'consumer' because for me it is not a market transaction. It is actually a human right to have access to health services, be it mental health services or others, but the people who receive the care are far too often the most powerless in the system.

Mr Dawber: I think that sort of committee or group that you are talking about is reflective of the reality of clinical practice and multidisciplinary methods. It would make sense that it should have those representatives, but it is the process. It is the way that they interact that is important.

CHAIR: One final question from me. The Queensland government recently announced an expansion of the trial of GPs in high schools, and that will potentially have an impact on responding to the needs of youth mental health. There have been nurses present in schools for a very long time. Would it be the view of the QNMU that there is greater scope for expanding the scope of practice of those nurses, particularly in relation to playing a role in the mental health space?

Ms Mohle: There certainly is a great need to expand the scope of school health nurses. We would really be advocating for more school health nurses, particularly focusing on issues like mental health and particularly given the absolute explosion of eating disorders being experienced by both young men and women in schools. There really is a great need there to expand the school health nurse program.

CHAIR: Do you have data on the increase in eating disorders amongst teenagers?

Ms Mohle: There certainly has been. I have to say that there are not enough specialised services to deal with that across the state. Chris, did you want to comment on that?

Mr Dawber: No, just to agree with what you have said.

CHAIR: I will not take that on notice, because we do have Eating Disorders Queensland coming along.

Ms Mohle: Certainly that is the feedback that I hear from family and friends, actually. It is just an explosion. There is not the specialised services. Families are actually really struggling to find the specialised services to deal with this. It is an area that needs great attention.

Mr Dawber: Anecdotally, I can support that from my clinical practice and consult liaison. We are seeing that.

CHAIR: Chris, I would have a lot more questions for you about your work with supporting health professionals. It sounds like very interesting work as well. We have reached the end of our time for your evidence. I thank you all very much for presenting today. It really will help us to form our report and recommendations and hopefully improve the lives of people living with mental illness. I also want to thank all of the members of the QNMU for the great work they have done over the past two years. It is always challenging being a nurse or a midwife, but during a pandemic it is particularly difficult. I note that at last count, I think, 17,000 health workers around the world have died as a result of caring for people with COVID-19, and that includes doctors, allied health professionals and other health workers—a truly shocking statistic. We acknowledge those people and the great sacrifice they have made.

Proceedings suspended from 2.46 pm to 2.55 pm.

BASTIDA, Mr Rick, Member, South Queensland Branch, Australian College of Mental Health Nurses

GREEN, Ms Vicki, Director, Australian College of Mental Health Nurses (via videoconference)

HARRISON, Mr Jason, National Secretary, Australian College of Nurse Practitioners (via teleconference)

MACKLE, Ms Tracey, Member, Nurse Practitioner, Credentialed Mental Health Nurse, Australian College of Nurse Practitioners (via videoconference)

CHAIR: We will reconvene this hearing of the Queensland parliament's Mental Health Select Committee. Welcome to you all. We have people in person, on video link and on the phone. We will push ahead. I invite each organisation to make a very brief opening statement and then we will go to questions from the committee members. Who would like to go first?

Ms Green: Hello, everybody. I am very sorry I cannot see you face to face; Zoom has let me down. I am a mental health nurse of some 32 years and I am a proud director of the College of Mental Health Nurses. I am very proud to present here today on behalf of the college. I have some priority areas to talk about or do you want everybody else to introduce themselves first?

CHAIR: Could you give a brief opening statement and then we will go to questions.

Ms Green: My brief summary is that mental health nurses are the largest health profession dedicated to the provision of mental health care. We are geographically dispersed and a cost-effective workforce component of the mental health system. The College of Mental Health Nurses has a growing and active membership in Queensland, working across a diverse range of settings including public bed-based care, community mental health services, hospital consultation liaison, primary care, and drug and alcohol services. We have a comprehensive skillset and advanced scope of practice in a range of speciality areas. We have a lot to contribute to the mental health system. I welcome any questions from there.

CHAIR: Did someone from the Australian College of Nurse Practitioners want to make an opening statement?

Mr Harrison: Nurse practitioners can manage literally straightforward anything, with or without complexities, in most specialities, including primary care and in all geographical locations. If all stakeholders in health and government work on this premise, it will open up all doors for government on how it can address the health and mental health needs of communities we service. This will essentially catapult us forward in how we address health issues in our great state of Queensland as we will no longer be bound by the current constraints in thinking regarding the way we deliver health care. Rather, it will enable stakeholders of health care to consider how they can enable the current workforce to improve access to evidence based and financially stable mental health care and addiction services in Queensland.

Fundamentally, the ACNP submission looks to address three points to improve the access of patients to mental health and addiction services in Queensland. The first is how you can utilise the nurse practitioner and the nursing workforce to deliver healthcare and addiction services. The second is about building workforce capacity and community resilience in addressing mental health and drug and alcohol issues in communities. The third is the relationship between the Commonwealth and the state government in the provision of mental health care and addiction services in Queensland and the barriers that impede a person's access to evidence based, affordable health care.

CHAIR: I want to start with those three points that you raised and I will ask a question about each of them because they are each very important. Let us talk about the Commonwealth and state government delivery of various parts of health services generally but specifically mental health. What do you see are the barriers and what can be done to address those?

Mr Harrison: There are a couple of things in regards to the state, and I will start with the state first because it is probably the easiest. There could be some amendments to legislation. The new Medicines and Poisons Act impedes nurse practitioner practice. It limits the ability to prescribe certain mental health medications to patients. The Commonwealth government already has approval for nurse practitioners and practice nurses. There does need to be some amendments there. There could be amendments in legislation. Where it says 'medical practitioner', you could also refer to 'nurse practitioner' and that has really enabled nurse practitioner workforces in New Zealand and also in the USA in the delivery of health care.

There are probably a couple of things from the state perspective. When the health minister goes to the COAG meetings for health issues, it is really pushing on the feds to enable both nurse practitioners and nursing to have access to MBS item numbers that allow for primary healthcare provision of mental health services. That also creates that community resilience and takes some of the emphasis on that the state has to provide everything to the patients within the state areas.

There is obviously pushing on the feds in regards to giving nurse practitioners better access to MBS. From a statewide point of view, we also have the issue that certain policies within Queensland Health, especially around specialist appointments, impede my ability as a nurse practitioner who works in the public system to refer a patient to specialist clinics because I do not have a provider number. That is a significant barrier, especially when you are talking about patients with metabolic disorders or who require other interventions that a specialist needs to confer on. There are those sorts of things that need to be addressed.

Obviously, from a statewide perspective there also needs to be better planning of mental health services and looking at the nursing and nurse practitioner workforce within mental health and obviously drug and alcohol services. It requires a good strategic plan for the workforce and looking at how to do that best, especially in areas of need, in regards to how we address some of the shortfalls in mental health services in particular areas, especially those geographically challenged areas. I work in Central Queensland. I cover a wide area doing clinics out at Emerald, Moura, Biloela, Gladstone and Yeppoon in regards to that. Obviously, there is support from a statewide level from telehealth models of care, but there is also the ability for Health and governments to look at options about how we deliver care—such as using private practice nurse practitioners to deliver care on behalf of the state and how that might look, so it is those contractual models et cetera. There is no provision under the current arrangements in Health to allow that for nurse practitioners.

CHAIR: I might jump in there with some subsequent questions. If we have a nurse with a basic baseline qualification and a number of years experience in a particular specialty area—let us say they have been working in mental health with or without specialist qualifications—how long does it then take them to become a nurse practitioner?

Mr Harrison: If they meet the requirements for the training to do their master's, it would take about two years to do the actual master's in regards to that. It is two years to do that program. When I did it it was about 18 months.

CHAIR: Is that two years full time?

Mr Harrison: I do not think they allow you to do that. They only allow you to do it part time with the way the subjects are done now, unless you are able to do the third semester within the university.

CHAIR: It is most likely that the majority of nurses would continue to practise during that time and do some study.

Mr Harrison: Yes. You practise but you learn. For a lot of the training and education, you do blocks of training at the university but the majority is done in your own time.

CHAIR: Vicki, in terms of mental health nurses, we have heard a lot about this missing middle—people get an initial diagnosis but the next time they get any real effective treatment is when they are in crisis for the most part. If we allowed mental health nurses and nurse practitioners to work to their full scope of practice, is there a role for nurses to play in responding to that missing middle and being able to provide services in that secondary space?

Ms Green: There is absolutely a role for mental health nurses in the missing middle. Mental health nurses are able to work across a diverse range of specialties and areas. Mental health nurses also can downstream into promotion, prevention and early intervention. Specifically looking at that younger cohort of 12 to 25, it was identified in the Productivity Commission report and multiple other state and national reports that early intervention is imperative and that mental health nurses are well skilled and well trained to be able to respond to that across a range of diagnostic areas as well as a range of specialty areas.

CHAIR: Tracey, did you want to add to that?

Ms Mackle: I am a credentialed mental health nurse and a nurse practitioner and have two master's degrees. I am able to provide an episode of care from the beginning to the end. Whilst we have this huge disparity in the 12 to 25s, we are also missing a lot of opportunities for early

intervention right from the minute that people are born. In the first three years in our infants, the foundations are being laid. In the next 18 years, those experiences that one individual will have will shape their health outcomes across-the-board for the rest of their adulthood.

Nurse practitioners in mental health, nurse practitioners in primary health and credentialed mental health workers can only complement the current workforce, the allied clinicians and our medical clinicians. We can provide therapy. Not everybody, depending on where they are at in their recovery journey, is ready to do intense psychological therapies, like CBT and DBT and some of the more mainstream. An eclectic approach that nurse practitioners and mental health nurses have picked up over time or additional training allows them to be able to buffer that gap and prepare someone for the more intensive part of therapy. Some people may never get there. Some people have difficulties in working in those kinds of modalities, so it is about having flexibility to offer different opportunities for people to grow and to be able to live a life worth living with their mental illness.

Mr MOLHOEK: The submission from the Australian College of Mental Health Nurses states—

> Mental health should not be a separate curriculum but be included in the nursing or midwifery undergraduate degrees to build a flexible, holistic and integrated mental health workforce with the capacity to address mental health concerns and suicide prevention across all health services.

I am interested in your comment around that. Does that also provide greater scope for variety within the job and future prospects?

Mr Bastida: The idea of comprehensive training in undergraduate nursing degrees has been around for a very long time. The college does talk about direct entry courses, which is a three-year undergraduate mental health nursing-specific course. There is certainly value in having comprehensive undergraduate degrees—whether that is with a fourth capstone year or as part of graduate programs that are supported and then work with universities to have a credit towards the graduate diploma or graduate certificate leading on to a master's if people want to traverse that.

Having the same grounding as other nursing graduates has value. What it needs is more mental health components in that comprehensive undergraduate training. As the earlier witnesses were saying, that is the idea of generalists having greater access to training around mental health, because people with mental health conditions, whether they are minor or severe, are everywhere and will come through all parts of the health system so they are needed equally in all the other non mental health parts of the health system as they are in the mental health system itself as a specialty.

CHAIR: As a follow-up question, you talk about the need for the mental health skills in generalist nurses as well. I certainly know from my practice that, if we had a patient we wanted a mental health review of, a psych team would show up, do an assessment, write some things on the charts and wander off—and they would do a good job. However, for those of us who were there in the ongoing care of the patient, there was not a lot of guidance around how to manage a patient who was having mental health issues. There were times when we would have mental health nurses doing student supervision so they were spending a lot more time on our wards, and just by and by they would provide assistance and guidance around how to respond to certain situations. I personally found that to be quite useful. I know your role in Queensland Health, Rick. Is there work being done around trying to increase the skills of people in that physical health space around mental health care? We have certainly had feedback through this committee that when a person with a mental health issue goes into hospital for a knee replacement, for example, they do not have the greatest experience.

Mr Harrison: What has happened over time in regards to mental health and having more identified training in the undergraduate program is that we do have a vacuum now where we do not have trained, skilled clinicians working in services. You are looking at about a two- to three-year investment in general registered nurses to get up to skill to be able to work in an inpatient service or even in community fluently to deliver effective, efficient care like that. Some of my colleagues may disagree, but that is what I have seen in practice and I know that is what happens within drug and alcohol, because we have lost that identified training over time where we used to have specifically trained mental health nurses.

In regards to experiences for mental health patients and metabolic monitoring et cetera, sometimes when things are identified we feed that back to general practice but it is not always implemented. That is sometimes due to time constraints and patient factors. Then when patients present to hospital, there is a stigma that they are mental health patients and staff are not quite as skilled or trained in their management. The patient may be a little stressed or anxious about the fact that they have to have a total knee operation and sometimes there is a lack of willingness to support patients in those hospital settings in accessing, say, the mental health consultant liaison services until there is an issue.

Some of it is about communication. Some of it is about training and educating staff to be able to manage people with mental health issues in the inpatient services and treat them with the respect they deserve. Tracey might be able to add more because obviously she is working in that acute setting as well and she would have experience with some of her patients who have had to access hospital based services.

Ms Mackle: I think it is about capacity building. The only way you can really improve the capacity of generalist staff is to be working closely with them and, unfortunately, we all work in our silos. You have just highlighted that, within a medical unit, the CL team is called in. The CL team are usually one or two people who cover every single admission ward in a hospital. To be able to spend time with staff and to be able to role model how to de-escalate situations and to be able to spend time with patients—it just does not happen. There is no true integration of the mental health workforce within the medical teams.

I work in the perinatal service. We cover the whole of Metro North, including three birthing hospitals so it is about being able to get there. We know that we have really skilful midwives who are absolutely freaked out by some of the presentations and trauma that our patients present with. But if we were able to manage their anxiety and support them in some of the questions that might be helpful to ask and some of the ways to de-escalate situations, that would improve outcomes immensely.

Ms Green: I would use that as an opportunity to demonstrate the diversity of skill sets for mental health nurses. Taking your point around consultation liaison, mental health nurses can get called in anywhere from the emergency department to the birthing suite. We are across a range of disorders; we are across a range of skills. Yes, I agree with Tracey: we also have an amazing skill set around building capability for other nurses and other medical practitioners. I wanted to highlight that to the committee today because we are across so many specialty areas—forensic, perinatal, drug and alcohol, child and youth, and the list goes on. We respond to their medical needs, we respond to the emergency department and we respond to the community. It really is such an opportunity to highlight the diversity and skills of mental health nurses.

Dr ROWAN: My question may be to the Australian College of Nurse Practitioners, so either Jason or Tracey, but I am happy for any of the panellists to answer. How can nurse practitioners be further be utilised in Queensland's Alcohol, Tobacco and Other Drugs Services? We know that there is a huge shortage of prescribers in relation to opiate substitution therapy programs. How could they be further utilised? Secondly, there is an alcohol and drug information service run out of Biala, which provides advice across Queensland and, as I understand it, is managed and operated via addiction medicine specialists. Equally, there could be nurse practitioners involved. Should there be a similar mental health 1800 number in Queensland—with psychiatrists and nurse practitioners—to provide phone advice? Would that help the system?

Mr Harrison: In regard to nurse practitioners and the opiate treatment program, I am a prescriber and I train prescribers up here. I have trained one of my mental health colleagues as well as a nurse practitioner who works within the correctional system. The issue is that we have not had any investment in positions within the public program to expand that option of utilising nurse practitioners as prescribers. But that does not stop private practicing nurse practitioners also becoming prescribers. There is definitely an opportunity to use them to their full potential and work in the drug and alcohol space. It is about how we make that happen and allow options for people to be able to access training while engaging with patients in the community.

One of the big barriers for private practising nurse practitioners in the drug and alcohol space is to do with the Commonwealth government's limitations and access to NDIS and being able to support patients. As someone who works in drug and alcohol, I just do not do opiate treatment. Obviously, I deal with dual diagnosis patients; I support them with their mental health issues. For those patients, when general practice will not prescribe medication, I support them in the continuation of their mental health medications. I do hepatitis C treatment, as well as looking at some general health issues for particular patients when there are barriers in accessing general practice.

In regards to having a 1800 number for mental health, there are a number of services that already provide that access. I think it would be useful and having access—and probably even for patients and health practitioners—access to support patients would be great; it is whether it is sustainable or not. I know that ADIS do a great job from a drug and alcohol perspective in providing and linking people into care, as well as providing information. Obviously, there is the addiction specialist hotline number that gives health practitioners access to them when they are looking after patients. There is definite benefit and merit in it in that nurse practitioners definitely could be used in that space.

Again, it comes back to having a strategic plan for nurse practitioners working in public areas and how we grow that work. There is nothing in situ at the moment from the top level of the Office of the Chief Nursing and Midwifery Officer that could help that nor from the branch. We do need some significant health planning within mental health in general, as well as drug and alcohol, about the structures and what it looks like. We need to go back to a model of dedicated positions rather than generic positions, because that has diluted some of the care that patients receive. How we better utilise our credentialed mental health nurses in mental health in regards to providing patient care, both publicly and privately, I think is undervalued. We are not optimising their full value or use in communities.

Mrs McMAHON: In relation to the undergraduate degree that our generalised nurses undertake, should there be a specialised undergraduate degree in mental health or should it be within the realm of postgraduate studies where someone specialises in mental health?

Ms Mackle: I would like to offer a comment around that. I am a comprehensively trained nurse from New Zealand. I have primarily worked in mental health since I graduated. You cannot separate a human being into parts; as a mental health nurse, somebody's physical health is just as important. Particularly in the field I work in, I have to be thinking about—in my prescribing and in the care that I am providing—what is going on for someone physically, whether they are growing a baby or in the postpartum period. It is the same when you work across any other field. You ask: what is their physical health like; are there problems with obesity; are the drugs that we are prescribing to keep them well causing other problems?

As a comprehensively trained nurse, I would not want to see a straight mental health undergraduate degree that did not set people up to be able to consider those other factors. If you are not well trained, someone who presents with a severe anaemia or iron deficiency will have the mimics of a depressive symptomology. Someone who has a hypothyroid condition is going to mimic depression. If we do not have clinicians who are well-rounded in their training, they will not be able to think about the other compounding factors. Following your comprehensive training, I like the idea of the three plus one: you move into your speciality and do some more focussed training around that.

Mrs McMAHON: When you say 'three plus one', that is still a four-year undergraduate degree?

Ms Mackle: Yes.

Mrs McMAHON: As advocates for workforces, how much engagement do you have within the tertiary sector to be able to influence or drive the curriculum and the training that is on offer by our universities around mental health? Earlier today, we heard that a typical nurse undergraduate degree might only have four subjects over a four-year period in mental health. Is that enough, is it timely and is it current?

Ms Mackle: One in four people have a mental health condition so I would say it is not enough to have four subjects over a four-year degree.

Ms Green: I wanted to speak to the four plus one, which is outlined in our submission. If people want to ask more questions, that is absolutely fine. The transition support program is supported by our partners from the chief nursing office. It enables people in their postgraduate year to work with HHSs and with the university tertiary sector to develop their mental health skills as a specialist area in that fourth year, so as graduates. It is a nice combination of clinical skills and formal qualifications. I would certainly advocate for an expansion of the TSP program, as well as some funding and resources to evaluate that effectively at a state and possibly even a national level.

Mrs McMAHON: With a focus on the primary training in mental health being in the postgraduate year, to me that sounds like a barrier for many people who might struggle to do their undergraduate degree while they are working or they have kids. To then ask people to go on to do postgraduate study—notwithstanding that there may be a scholarship or it may be done whilst they are working—is a huge ask when you are trying to live your life as well. I know that the nursing qualification has one of the highest rates of mature age students when compared to many other qualifications. To then tell someone that they have to do postgraduate study in order to get accredited, to a layperson certainly seems like a barrier.

Ms Green: I think that is the beauty of the transition support program, because the transition support program enables the graduate to be employed by the health and hospital service, so there is actually paid employment while we learn and study. It also creates an opportunity for them to have access to highly skilled practitioners in the workplace to develop and nurture those skills. I agree that sometimes tertiary education is costly and time consuming, but I definitely think that we need that professional level of education and support to enable that, which I think is nicely combined in the transition support program in that fourth year.

Mrs McMAHON: The other question I had was in relation to the level of engagement that you have with tertiary institutions. How much feedback are you able to give them on the standard and quality—I will not say the graduates—of the courses that they put the graduates through? Are they accepting of the feedback? Do you see them being responsive to what is happening on the ground at a professional level?

Ms Green: Yes. Each work area or HHS has their own relationships, usually established on location and regionality. I can certainly say that we have a wonderful relationship with our tertiary education partners. We provide real-time feedback around student placements and preset the students when they come into the mental health placement. Currently, the commitment to mental health placement in the second and third year is very small—120 hours. It is not enough to get across the diversity of skill set that is required. But that being said, we are able to link the students up with skilled mental health nurses to provide them with the best possible placement that we can to really create a pathway opportunity for them to come back to us in the transition support program or in their graduate year and work with us more comprehensively. It is a very difficult space. In that undergraduate program there is a lot to cover. Certainly, my experience has been that the tertiary sector is very open to feedback.

CHAIR: I want to ask a question of Tracey, given your experience and your current work situation. We have had significant evidence around the contribution to mental health issues later in life if we do not get perinatal mental health right and that early childhood and parenting period. What do you think the opportunities are for us to improve services around perinatal mental health and/or early childhood and parenting services? Is it just a matter of more? Do we need different models of care? What do we need to do?

Ms Mackle: There are always opportunities to look at doing things differently. At the moment, the funding is broken into two arms—child health is funded by children's health, adult mental health is funded by adult mental health. Perinatal and infant mental health are integral to each other and yet, in terms of funding, different people have different catchments. You can work in collaboration but you do not get true integration, because you are in different areas. Whilst I can offer a service to someone who is in this particular postcode, I cannot offer it to somebody else—even though they birthed in my area—because Children's Health Queensland do not cover that area. We have different geographical catchments.

There is room to integrate our child health nurses and our midwives, especially for women who have complex and enduring mental health conditions, so that we are working closely together. In your work as an MDT, you are able to support women through from their antenatal journey into their postnatal journey. We upskill child health nurses and midwives in mental health and we try to reduce the infant's exposure to adverse childhood experiences. When parents are well mentally and are not using excessive substances, there is hopefully a reduction in domestic violence. We know that if we can get some of those things right, the projections for physical health by the time children become adults is way better by being able to re-examine funding and join services together, instead of working in our silos. We all have skills to offer, but we can do it together. I would love to have a child health nurse working in our perinatal mental health service. I would like to have infant clinicians working in our team, but we are funded for adults.

CHAIR: This afternoon, the QNMU told us that mental health services for people who live in age care are almost non-existent. We know that there are challenges in rural and remote Queensland, particularly in Indigenous communities. We know that there is a lot more that we can do for people who are incarcerated, or shortly after they are released. We know that there has been some movement in terms of expanding services in schools, particularly state high schools and primary schools. Are there opportunities for nurse practitioners generally and nurse practitioners as mental health specialists, to play a role in these areas?

Mr Harrison: The short answer is yes, but it is about what you want to achieve. The models of care can be varied and unique to each area, but the issue is how it is supported. In Indigenous areas, nurse practitioners from a federal point of view need better access to MBS—if you want them to work in NACCHO organisations—to be able to deliver care and to support those patients. In correctional centres, nurse practitioners are already invested in those areas. Having better access to mental health services would go a long way. Obviously, the OST program in jails is another. It is not cemented in those areas yet.

There needs to be an investment in drug and alcohol services in the community. The problem is that, whilst we might invest in more prescribers, if there are no areas for those patients to go to or no services to support them when they return to the community, they are set up to fail. They return to

that recidivism behaviour of criminality and that does not help them. Nurse practitioners can definitely play a role in all parts of those areas—primary health care, the early identification of mental health issues and supporting patients to link in. They are credentialed mental health nurses.

Again, it is about having community resilience. There has to be a combination of both the Commonwealth and state working well together to achieve that overall goal of better mental health services for patients to access in our community. Telehealth is a great model but not every patient has access to a smartphone. Some of the thinking is about—how do we make sure people have access? Some people are geographically challenged. I have patients in rural communities who cannot travel 100 kilometres to go to a health centre for a telehealth appointment. Some of the technological support to help that is not there—the NBN and such.

Ms Mackle: Mimicking what Jason has said, there are some reviews around legislation. If we are talking about nurse practitioners working in the community in rural and remote areas, then the legislation around the Mental Health Act needs to change. Where it says 'medical practitioner' it should also include 'nurse practitioner' so that we are able to—at least in the beginning parts of the Mental Health Act—do those assessments and work independently when there is no medical person available.

Dr ROWAN: I wanted to ask a question regarding our prisons in Queensland. Given the prevalence of mental health and alcohol and other drug disorders, nurse practitioners are involved in our prison settings within some of the health services. Is there an enhanced scope and model of care that could be provided to address some of those issues before people transition back into the community under parole arrangements? Do the panel members have any comments or recommendations about models of care involving nurse practitioners and/or additional services that could be provided in prisons?

Mr Harrison: There are probably a couple of things. Obviously, we have nurse practitioners at the moment. New South Wales has taken a silo approach in regard to how they address correctional health. They have primary health care nurse practitioners; they have drug and alcohol nurse practitioners; they have mental health nurse practitioners working in facilities. There is a direct access to care at any one time. That is a possibility that could be looked at.

We have prison teams already. It is about how you might enhance some of those things with a nurse practitioner position—not just mental health, but drug and alcohol services to support correctional health. The issue is still the transition from prison back into the community and about the investment in regard to the current existing services, both in primary health care and mental health and drug and alcohol services. We need staffing resources to support those patients coming back into the community, especially when they are trying to access services such as counselling, opiate treatment programs or withdrawal or rehabilitations services. It is about how we have those linkages to support it.

They have some programs in place in different areas that work quite well at integrating patients. At the end of the day, the barrier is when patients come back into communities. In SEQ at the moment we have a waiting list for access to OTP, so even if you are a prisoner getting out there is no access for you to the program, even though you are a priority patient, because we have reached our numbers. We have got no dosing points or pharmacies to support patients coming in, or staff to support the long-acting injectable team to increase numbers there. There definitely needs to be an enhancement in services across the board, both in mental health as well as drug and alcohol services. We need to look at how we resource our services and plan our services.

The issue has always been that it seems to be very easy to get a medical officer to be employed, but to obtain support positions or a nurse practitioner is a lot harder. Even if you have a prescriber, you still need support staff for case management to support patients back into the community. The patient does not just come with a drug and alcohol issue, they come with social issues such as housing, financial issues and family issues. They need access to parenting programs or linkages into those programs. They need support with NDIS applications et cetera.

You need positions that support your prescribing or treatment positions. We need to have more people, both working in the public system and privately, to have community resilience. The focus is not on the Queensland government supporting everything—the idea is that both the Commonwealth and state work hand in hand so that there is equity in the system to give patients treatment options. Government services run nine to five. If I work privately, I can offer alternative options for patients who work to have later appointments so that they are able to access treatment.

CHAIR: I would like to thank all of you for taking the time to appear this afternoon. The information and experience that you have shared with us is certainly going to be useful in formulating our report and recommendations. We want to thank the members of your organisations for the work

you have done, particularly over the last 2½ years during the pandemic. It has obviously been an extremely difficult time to be a health professional. We appreciate the work that you have done. Thanks very much, everyone.

Proceedings suspended from 3.41 pm to 4.02 pm.

CHU, Mr Charles, Social Policy and Advocacy Officer, Australian Association of Social Workers (via videoconference)

NEWTON, Mr James, Accredited Clinical and Accredited Mental Health Social Worker, Australian Association of Social Workers (via videoconference)

CHAIR: I officially reconvene the select committee into mental health. I welcome from the Australian Association of Social Workers. Charles, did you want to make a brief opening statement and then we can go to questions?

Mr Chu: Sure. Good afternoon members of the Mental Health Select Committee. The AASW welcomes the opportunity to give evidence on this important inquiry. Today I will be joined—very soon—by James Newton who is a Queensland guy, an accredited mental health social worker and an accredited clinical social worker. The AASW is the national professional body representing more than 15,000 social workers throughout Australia, including more than 3,200 members in Queensland. The AASW works to promote professional social work, including setting a benchmark for professional education and practice in social work while also advocating on matters of human rights around social justice. Social workers work with people with complex mental health presentations across the gamut of social service systems: hospital, community-based mental health programs and private practices in Queensland. In particular, accredited mental health social workers are experts in complexities and have been providing focused psychological strategies under the federally funded Better Access initiative, delivering more than 86,000 counselling sessions to Queenslanders every year.

In preparation for our submission to the inquiry, we have surveyed 150 generalist and mental health social workers in Queensland. Their responses highlight the urgent need to revisit the pillars of the Queensland mental health system: the workforce and service delivery. The submission provides a range of recommendations relating to service models such as social prescribing, school social work as well as workforce issues. I will talk speak to those issues briefly. We welcome follow-up questions.

First of all, the social work workforce in regional Queensland needs to continue to grow exponentially over the next five years with significant growth in the Sunshine Coast, the Queensland outback and Cairns. Addressing the supply of mental health workers requires a multilayered approach that considers both the recruitment and retainment of highly skilled social workers. What it needs is a generous relocation package and further investment in student placements, ensuring the supply of workers into the mental health system and increasing the job satisfaction of current workers. Secondly, there are a lack of accountability measures for people who are employed to undertake social work roles within the state mental health system. Since social work is not a registered professions, everyone can call themselves a social worker without being held accountable by an independent body. Implementing a statewide social work registration scheme, like that in South Australia, would benefit employers and the public by ensuring that only people with the relevant qualifications and subsequent skill will be staffed in those roles.

In terms of service delivery, there is not consistent provision of mental health care at Queensland state schools. The Productivity Commission and the Victorian mental health royal commission both highlighted the benefits of employing qualified social workers at school. We refer the committee to the Victorian mental health practitioner at school program which employs social workers in every state, secondary and specialist school. Secondly, there has been a great divide between state and federal mental health systems. This has caused vulnerable Queenslanders to fall through the cracks. We have heard of experiences including of people being transitioned from state mental health services to the NDIS, and private practitioners who also work within the federal funding stream wanting to provide services within the state mental health systems. The better utilisation of resources embedded in both systems could lead to better health outcomes for vulnerable Queenslanders. Moving forward, we affirm that workforce and service delivery are the foundation of a better mental health system for all Queenslanders. We welcome questions.

CHAIR: Thank you. I welcome James Newton, an accredited clinical and accredited mental health social worker, who has joined us via video link as well. Thank you for joining us. Your submission talks about the social prescribing program that has been rolled out in the Mount Gravatt Community Centre, Ways to Wellness. I am familiar with that. They do some work in my electorate. Can you talk about how expanding that might help to deal with the missing middle if that is in fact what it will do?

Mr Chu: The AASW is quite supportive of this model because we see that some of those who have mental health concerns and go to their GP sometimes may not need clinical or one-on-one talking therapy. What they need are community supports and services. That is why linking GPs and

linking medical professionals to social work services will create a great opportunity for people to be connected to the community and be supported by other community members. James is an expert in mental health, so I guess he can further add to my point.

Mr Newton: I do not have a great deal to add to what Charles has just mentioned, except that social workers have a great deal of expertise and skills in terms of psychosocial interventions, particularly when it comes to early intervention and mild to moderate interventions such as supporting people with anxiety, depression and addressing social isolation. These are areas that social workers have been involved in for decades and have been at the forefront of that kind of work.

CHAIR: We have heard a lot about workforce issues. It seems as though in a lot of areas we have funding to deliver some services but often not the staff and the clinicians that we need to deliver those services. What is the situation in terms of social workers and what should we be doing to try and increase and expand the scope of practice for social workers?

Mr Chu: There are a few components that can answer your question. First of all, it is increasing the numbers of people who get into this profession, especially the mental health clinical field. As we observe, mental health is a quite challenging field for people to get into. Usually, employers prefer hiring people with past experience or clinical placements in mental health fields before they even get an entry level Mental Health Clinician job. One of the major themes that we find really important is to invest in social work placements. Those placements are in community or state mental health services. We have found that there are lots of students now currently in QUT or UQ, but they struggle to find placement hosts.

One of the proposals in our submission is that we encourage the government to invest by creating incentives for smaller or medium sized mental health services, especially community-based programs, to employ a social work supervisor on site. That has been quite useful in how some of the universities in Victoria have been trying to creatively increase the number of placements. When the organisation has the capacity to supervise students, the students will have a good placement outcome. It leads to them finding it easier to find a job within the mental health sector. One way to tackle this to ensure that social work students have enough exposure to the mental health sector before they even enter the workforce.

The second thing we touched on in our submission concerns the regional relocation initiative to make sure that people from metropolitan areas not only in Queensland but all around the country have the incentive to go to regional and remote Queensland and to work in some complex mental health work. In terms of a relocation fund, it would enable people to move—some have families—to regional and remote areas. Secondly, it is the ongoing supervision that has been paid for by the scheme or by the fund. Now we know that a lot of mental health workers have to pay for their own supervision or pay for their continuing professional development. Thirdly, we need to make sure that there is ongoing support when they relocate to those areas. That includes both peer support but also financial support so that remuneration and their rates are above award. They are the three survey outcomes that our members in Queensland have told us. These increase the chances to recruit people into regional and remote areas to do mental health work. James, I am not sure if you have anything to add?

Mr Newton: No, thank you, Charles.

CHAIR: You talk about relocation or the opportunity for people to work in regional and remote areas. Is that during their undergraduate study? Is that during their practice? Is it just placements? Are you talking about relocating permanently?

Mr Chu: That has to go both ways. One of them will be some placement opportunities so people have the incentive to go to regional and remote areas, do the placement and stay in the community where they are placed. It is more about, 'Where are your opportunities?' What can interest people who graduate from metropolitan universities with a social work degree to go to regional and remote areas? That is the major part. A financial incentive will give people a better chance once they graduate on the Gold Coast or in Brisbane to say, 'Maybe I will do a few years in Townsville or in Cairns.' They are the two points of investment that I think are worth doing.

CHAIR: Your submission talks about a state-based registration scheme and recommended that we establish one. Have any other states gone down the path of a registration scheme? Would it be better to look at that more as a national approach through Ahpra as other registered professions have done?

Mr Chu: AASW have always been advocating for the inclusion in NRAS which leads to Ahpra regulations. The recent success in South Australia has demonstrated that there is a space for our state government to take up the opportunity to introduce a social workers registration scheme. What

we have seen in South Australia is that they will establish an important board that will define what social work is, what the social worker role is and what level of qualification is required to be considered a social worker, as well as defining and developing the ethics and the practice standard so they have the power to hold individual workers accountable. This could have an impact on the workforce to ensure the highest quality of the mental health workforce in any space or the social worker workforce in any state. James, do you want to fill us in on how it could impact the mental health workforce in Queensland?

Mr Newton: As Charles mentioned, the AASW has for many years been advocating that social work does become regulated through Ahpra. As a self-regulating association, the responsibility that the association has taken is looking at ethics complaints and ensuring the continuing professional development requirements and supervision requirements are being upheld. I found that, as a mental health social worker and as a clinical social worker, if we went down the path of either Ahpra or a state based regulation approach, it would put us in good stead with other allied health professions such as psychologists and mental health OTs who are Ahpra registered.

To give confidence to the community, those quality checks are being put in place at the same level as those other allied health professions, ensuring that GPs are aware that social work is a trustworthy profession the same as psychologists and mental health OTs who are critical in mental health service delivery. Amongst all different allied health professions, we want to make sure that referrers and service providers are making the most out of all of us.

As I mentioned before, social workers have a lot to offer in terms of providing supports to the mild to moderate end of mental health concerns. Without that kind of assurance to the community and to the medical profession to refer us, there is often a gap where we see waitlists ballooning because psychologists are often thought of as the go-to profession in the mental health service.

Mrs McMAHON: I think you said your organisation had 3,200 members in Queensland; is that right? Obviously social work is a very wide and varied field. You work in youth, alcohol and drugs and all of those kinds of thing. How many of those 3,200 would be predominantly working in the mental health space?

Mr Chu: I would have to take that question on notice, but we do have that number in our database. I can get back to you on that.

Mrs McMAHON: Of your 3,200, or even within the mental health space, how many would be considered peer workers, as in those who have lived experience in the fields that they are working within?

Mr Chu: We do not have that data on our database. James, do you have any comments to add in terms of peer workers in social work?

Mr Newton: I certainly would not have any data to answer that question. I can say that there are a lot of social workers. There are a lot of non-social work workers in the mental health spectrum who would identify as peer workers. That is a growing space as well in terms of more and more people with lived experience becoming comfortable and aware of the opportunities to identify as peer workers with lived experience.

Mrs McMAHON: A suggestion has been made to the committee that we should be aiming for a certain percentage of workers within the mental health space to have had lived experience. In relation to your submission, you referred to the Productivity Commission's recommendations of the 1:500 ratio of qualified social workers to students. The nurses seem to think that that is 1:500 in terms of a mental health nurse. Was that 1:500 recommendation specific towards social workers or is each mental health profession claiming that 1:500 refers to them?

Mr Chu: That refers to the term 'mental health practitioner'. This has been claimed by psychologists—

Mrs McMAHON: Everyone.

Mr Chu: Everyone, yes. In Victoria, with the term 'mental health practitioner' four occupations have been looked at—psychologist, social worker, OT and mental health nurse.

Mrs McMAHON: Are you aware of how many of your members are currently operating throughout Queensland schools either as employees of Education Queensland or as individuals brought in by schools using their own funds to have social workers in schools?

Mr Chu: We do have that segregation in our database, so I can get back to you on that.

Dr ROWAN: With respect to the Australian Association of Social Workers and COVID-19, what feedback have you had from members in relation to what they have seen from a COVID-19 perspective?

Mr Chu: I think all across we are seeing growing demand in terms of social workers. We have some data from Services Australia in terms of seeking mental health social workers through telehealth. We have seen a 10 per cent increase in services that have been delivered by a mental health social worker through telehealth under the Better Access initiative. We have definitely seen the growth of service-seeking behaviour. Have you seen anything change locally in Queensland?

Mr Newton: I would like to also refer to our submission. Given the number of responses we had, we did get a sense of the common themes or the common issues that are presenting such as unemployment, social isolation and relationship breakdowns. Those are the really common issues that are being seen by social workers in Queensland. It is also something that we have heard a lot from members in relation to the inquiry into social isolation. It has been a big issue, particularly in the context of concerns about infection transmission, isolating at home, lockdowns et cetera.

Mr Chu: Yes. We put in a submission to another committee about the health impact of COVID-19 in Queensland. I am happy to send you our submission to that as well.

CHAIR: Thank you very much for that. That draws the time for questions for your group to a close. Thank you for making a submission and for your presentation here this afternoon. It will certainly help us to formulate our report and our recommendations. On behalf of the committee and the Queensland parliament, I ask you to pass on our thanks to your members, particularly for their work over the last couple of years during this pandemic. It has no doubt been an extremely difficult time for health workers. You have taken a number of questions on notice. We ask that your responses be supplied to the committee by the close of business on Friday, 18 March. Thank you very much for your time here this afternoon.

CARRISON, Ms Tegan, Executive Director, Australian Association of Psychologists Inc.

CURRAN, Ms Amanda, Chief Services Officer, Australian Association of Psychologists Inc.

CHAIR: I welcome from the Australian Association of Psychologists Amanda Curran, Chief Services Officer, and Tegan Carrison, Executive Director. I invite you to make a brief opening statement and then we will go to questions.

Ms Curran: We are seeing a huge spike in mental health challenges. A lot of things are contributing to this. The COVID-19 pandemic and the recent floods are contributing factors. We are seeing quite an increase in anxiety and post-traumatic stress as well as depression in Queensland.

There are two main issues for people who are needing services. They are access and flexibility of service delivery to meet the needs of the individual. Access issues include barriers such as entry requirements for treatment services excluding a large majority of consumers; red tape required to gain access to private services; difficulties navigating the system; and lack of culturally appropriate services, particularly for youth and Aboriginal and Torres Strait Islander people. The restricted way that services are provided also reduces the cultural appropriateness of services as well as reducing the ability to engage in multidisciplinary treatment

The two-tier Medicare system for psychologists is also a significant barrier to accessible care. This places psychologists into two categories: clinical psychology services and general psychology services, with two rebate amounts that are significantly different and one that offers less rebate to the consumer. That affects 70 per cent of people who are accessing psychologists. They are getting less rebate than they are for seeing clinical psychologists. On average, clients are paying $175 for each session, yet only able to claim $88.24 from Medicare for the majority of services provided. Many clients cannot afford these out-of-pocket expenses, reducing the number of people who are able to access care or receive care for the amount of time required to become well. The costs associated with mental ill health are clearly outlined in the Productivity Commission report on mental health.

We propose investment initiatives that will make a significant difference to the outcomes for Queensland: the introduction of Medicare rebates for provisional psychologists; funding for psychologists in schools; easier access to psychologists; broadening MBS rebatable services to allow for early intervention as well as the treatment of families and couples, as well as assessments; rural and remote incentives for psychologists so that these communities have access to face-to-face services; culturally appropriate services; and increasing the Medicare rebate to $150 for the clients of all psychologists, removing the two-tier system and allowing more bulk-billing of psychology services.

CHAIR: Thank you for that. There are two different types of psychologists as far as the MBS is concerned?

Ms Carrison: As far as the MBS is concerned.

CHAIR: Can you step us through what those types are and what they can do and what they cannot do?

Ms Curran: The services provided by all psychologists would be expected to be of the same quality. You would expect you could see either type and receive the same amount of clinical care, the same quality of care. Under the MBS, you have one bracket containing clinical psychologists—which is one of the nine areas of endorsement. Then you have the other endorsed psychologists—which is forensic, clinical neuropsych, sports, organisational, educational and developmental, counselling, community and health, as well as those who do not have an endorsement—placed in the other bucket. The system does not make a lot of sense. You have one endorsement type in one category and all the other endorsement types and no endorsement over in another category.

CHAIR: The practical outcome of that is that if I am a patient seeking services I am going to pay a lot more for one than I am for the other.

Ms Curran: Exactly.

Ms Carrison: I think it is important to highlight that those with clinical endorsement do not have further qualifications, more education or more experience than the other areas of practice endorsement or those with general registration.

CHAIR: How do you qualify to be one or the other?

Ms Curran: You do one masters course versus the other masters courses. There is a practical training pathway as well where you can do two years supervision instead of the two years masters.

CHAIR: You discussed in your submission the need for the government to fund more psychology positions in community controlled services. You are anticipating there things like housing providers. Are there any other sorts of examples you can give?

Ms Curran: I cannot recall off the top of my head. They were listed. That was a recommendation from our Aboriginal and Torres Strait Islander expert reference group who work in those communities specifically. They said anywhere where consumers are going to come in contact with a government service then you need to have someone there who is qualified to be able to provide some support—so there is one door, you go to that door and you find someone who can help, rather than you have to jump through hoops and go and find somebody.

CHAIR: We have talked a lot about this missing middle. From the AAPI's perspective, how do we better utilise psychologists to try to deliver services in that missing middle?

Ms Curran: Often the clients who are quite unwell might be eligible for something like NDIS, but the difficulties with access to NDIS are significant. Unless they have someone willing to do some work for free to help them gain access, it is not going to happen that easily—so they need support workers and they need a psychologist who can come to their house instead of expecting them to be able to leave the house when they are so depressed that they cannot get out of bed every day. It is about changing the way that we provide those services. We have asked for funding for assessment, and that would go a long way. If there was an MBS item so that people could get assessed or if there was a way to get assessed through the NDIS, that would help people to access the right services at the right time.

CHAIR: The Queensland Alliance for Mental Health and the Queensland Nurses and Midwives' Union have both advocated for some sort of a community-based approach to the treatment of people who are not at that acute or crisis end of the spectrum. What is the view of the AAPI in relation to that?

Ms Curran: We would agree with that as well.

Ms Carrison: We would definitely support that. In our current mental health system, we sort of wait for people to be sick enough, and this is a dynamic that we urgently need to change. We want people to seek support early. We want early intervention and ideally prevention so that they do not escalate to these more acute services. That is very distressing to individuals, families and communities and it is also not cost-effective for the government to help assess. We do need to focus on that early intervention and preventive factor, which we see psychologists playing a very important part in.

CHAIR: If we set up a system where we were checking people's skin for cancers and we were detecting them but the next time we did anything about it was when they had a stage 4 melanoma—that seems to be what we are doing in mental health.

Mr MOLHOEK: I am interested to learn more about the financial model of practice. The Australian Psychological Society said in their submission that about half of all psychologists work in private practice. Do you need to have insurance?

Ms Curran: Yes. Professional indemnity insurance is required as part of registration.

Mr MOLHOEK: Could you walk us through the typical overheads in running a private psychology practice in terms of rent, insurance et cetera?

Ms Curran: We have got that all written up from a Senate inquiry that we attended. I am happy to forward that to you. It has quite detailed costs and what is required to work in private practice.

Ms Carrison: In summary, it is quite substantial. With the current Medicare rebate, psychologists by and large cannot afford to bulk-bill clients. This is why we urgently need that Medicare rebate increased. That takes into consideration all of those factors so that psychologists are able to bulk-bill those who really need to access those services. I will mention some figures for you. We surveyed our private practice psychology members in November 2021 and we asked some of these key questions—whether they are able to bulk-bill and what percentage of clients they are bulk-billing—and I think only five per cent of psychologists in Queensland are able to bulk-bill the majority of their clients. We then asked psychologists if the Medicare rebate was raised to $150 for a standard session how many of them would be able to bulk-bill the majority of their clients, and it was over 80 per cent. That is a very big difference.

Mr MOLHOEK: Amanda, I think you said earlier that the average is about $170.

Ms Curran: $175, yes.

Mr MOLHOEK: This morning we heard from the Family and Child Commissioner and he raised an issue that I thought was quite interesting. He talked about the fact that we need to see mental health a bit like we do physical and sexual health—that if you need to exercise and you need to lose

weight and trim down, you go to the gym and you get yourself on a program. He talked about the need for us to be more conscious around mental health generally. Notwithstanding that the system needs to be accessible for people who are at a disadvantage, I would have thought it was not unreasonable for people to have to pay something towards their own cost of mental health and wellbeing in some settings and circumstances.

Ms Curran: I think the problem lies in the way the system is set up—that you have to pay the whole fee up-front before you can then get the rebate. Paying a gap fee of $20 might be absolutely fine for someone, but if you are having to put $170 out and then wait until the next day to get—

Mr MOLHOEK: You can't hand your Medicare card over and just pay the gap?

Ms Curran: No. That is not allowed under the Medicare system.

Mr MOLHOEK: So there must be some psychologists who work out of medical practices or something where they have the ability to do that?

Ms Curran: Depending on the system that you use, there often are portable machines where you can do the claiming straightaway. Not everyone has access to those because of the cost of maintaining those machines.

Mr MOLHOEK: So the technology is there but it is the overhead costs of running it?

Ms Curran: Yes.

Mr MOLHOEK: Or if you are a single psychologist practice you perhaps do not want to have that.

CHAIR: Can I ask a supplementary question on that. Does any private health insurance cover the gap there?

Ms Curran: Not to my knowledge.

Mrs McMAHON: You mentioned the two-tier system and we briefly touched on it before about the difference between clinical psychs and the rest. In your submission you make reference to that particular system restricting access to the public for services. You said that examples of where this occurs include Centrelink, veterans' affairs, the public sector et cetera. Could you expand on that a bit in terms of who is being excluded and whether it is just that cost factor of clinical psychologists versus others? What do you mean by that two-tier system?

Ms Curran: There is some legislation, particularly through Centrelink, that requires a clinical psychologist to make a diagnosis around mental health. A psychologist could provide a treatment report but unless that diagnosis has come from a clinical psychologist it will not be accepted. We have lots of people who get denied a disability pension because they have the wrong psychologist who has provided the diagnosis. That is a base competence for all psychologists and all psychologists would be expected to provide diagnosis. The system has been set up to make it look like one type is much better than everybody else and it has flowed through many systems. In the DVA system, that is a financial barrier there because clinical psychologists again are getting a higher rebate.

Mrs McMAHON: You talk about the nine different areas of practice. I guess what you are saying is that I might have an endorsement as a health psychologist or a counselling psychologist, but given my level of study I should still be able to make a diagnosis under those circumstances. Is that your contention?

Ms Curran: Yes.

Mrs McMAHON: But currently various bits of legislation and policy preclude that and you must have that clinical neuropsychology or clinical psychology or just one of those?

Ms Curran: Depending on which system. Centrelink requires a clinical psychologist.

Mrs McMAHON: Not even neuropsychology?

Ms Curran: No.

Mrs McMAHON: That sounds fancier.

Ms Curran: They study the brain.

Mrs McMAHON: The other thing you linked to was the misidentification in relation to autism and those with other neurodivergence and the difficulty with someone who has been classed as having a mental illness when in reality they have a neurodiversity disorder. How often does that occur?

Ms Curran: I do not have any data on that, but anecdotally in my own private practice I have seen it quite a bit.

Mrs McMAHON: In children or adults?

Ms Curran: It is usually adults who have been through the system for a long time.

Mrs McMAHON: The perception is that if you have got to the age of 25 and no-one has said, 'You've got a disability,' then clearly you have a mental illness. Is that the general perception?

Ms Curran: Yes, or 'You behave poorly so you must have this personality disorder'—rather than 'You're overwhelmed by the system and we have not assessed you properly to find out what's actually going on.' That is because the services are just so pushed. I think everyone is working their hardest and doing their best, but there is just not time or funding to be doing those types of in-depth assessments that are required.

Dr ROWAN: Thank you for your submission and your comments so far today. There are a couple of points. The first is about the new Medicare Benefits Schedule items. The second is better indexation of the current Commonwealth MBS items to reduce out-of-pocket costs and increase access and affordability. The third one I want to ask about is this. When the Better Access initiative was introduced by the Commonwealth back in 2006, originally there were 12 sessions on referral, plus certain eligible individuals would be able to have an additional six sessions. That is now currently only at 10.

Ms Carrison: It is currently at 20.

Ms Curran: COVID has seen that increased.

Dr ROWAN: Is that a temporary or permanent measure?

Ms Curran: It is temporary.

Dr ROWAN: What is your recommendation about the number of sessions that needs to be there on an annual basis for someone who is referred? Have you provided any feedback to the Commonwealth through other inquiries about what that should be? Are you asking for those 20 on an annual basis?

Ms Carrison: We are asking for up to 40. The Productivity Commission's recommendation is up to 40 sessions. We are not saying that all individuals will need those, but it is important that the people who need those sessions have access to those. Our recommendation is up to 40.

Dr ROWAN: Would that still be on the basis of a mental health care plan completed by a general practitioner? How would people access those 40 sessions?

Ms Carrison: We would like a bit of flexibility around accessing these services. Our current model is very labour intensive for GPs. For someone to have better access they need to make an appointment to see their GP, they need to get in to see their GP, have a mental healthcare plan drawn up, a referral, and then they need to get an appointment to see a psychologist. In that first referral they can only have a maximum of six sessions. Then they need to go back to their GP for a review; then they get four sessions if it is clinically appropriate. Then they need to go back at the end of those four sessions to their GP and get another referral back to their psychologist for another 10 sessions. Then, if clinically appropriate, it is rinse and repeat each year. There are a lot of touchpoints and there are also a lot of barriers for people, especially if they are lower income. That can be another barrier to access. We would love some flexibility and the reduction of that red tape so people can access care in a timely fashion.

CHAIR: I know it is hard to generalise, but would it be fair to say that most GPs would rely heavily on the reports the psychologist gives them to make a determination about whether or not the session should continue?

Ms Carrison: Yes, that is a fair statement.

CHAIR: It seems like a fairly bureaucratic process to send them back there to read your report and say, 'Yes, you're on the right track, keep going.'

Ms Curran: Yes. In relation to access, given the current floods and everything at the moment I cannot see how many affected by the floods will be able to access their GPs. Some GP clinics have been flooded; they have lost all of their clinical records. Being flexible and being able to just present and see a psychologist—like with the bushfire items previously—would be much more appropriate for those individuals.

CHAIR: There were specific item numbers created for a specific natural event; is that correct?

Ms Carrison: Yes. I would love to just briefly talk about that if possible. One of our recommendations to the federal government at the moment is the expansion of the bushfire response Medicare item numbers. These were established in 2019 in response to the bushfires. Anyone who

was impacted by the bushfires did not need a mental health diagnosis, so once again this taps into seeking support early when it is needed so that individuals do not escalate to that high level of care. It enabled people to access up to 10 sessions with a self-referral to a mental health professional. It really enabled people to access services as quickly as possible without those barriers. We are recommending that those items are expanded to any natural large-scale disaster, including these most recent floods.

CHAIR: You could potentially link it to something like a natural disaster declaration and those sorts of things. I have another question that follows on from the member for Moggill's question. You talked about your desire to have up to 40 sessions. That is obviously from a clinical perspective what you think is necessary in some cases. What do we do with those people who need more than 40 sessions? Are there people who will benefit from ongoing open-ended counselling?

Ms Curran: They may be the people who are more appropriate for NDIS or some system like that, where you have other wraparound care and multidisciplinary teams that can provide that.

CHAIR: You are working towards a resolution of a particular situation. It is not just open-ended. If that is required, then is it a disciplinary approach rather than a clinical—

Ms Curran: Yes.

Mr MOLHOEK: Part of the journey with some patients is that often you will give them work to do, so they will have homework. They have to go away and have certain conversations or they have to think about certain things and come back. What happens if they come back month after month and they are never making the effort to respond to the challenges you put before them? Do you just keep taking them on the journey for 40 sessions and then forevermore?

Ms Curran: The code of ethics we are required to work under as psychologists states that we assess at what point treatment is not helping and then it is ethically appropriate to have the conversation about termination of services. There are lots of other therapeutic things you would do along the way to roll with that resistance: for example, try and work therapeutically; have conversations around, 'You keep coming here each week and nothing much has changed. Let's talk about the barriers. What's stopping you from putting these things into place?' Having that discussion and decision around is it more appropriate to refer you to someone else or a different type of service, or perhaps you are not ready.

Mr MOLHOEK: Maybe that particular psychologist is not a good fit for that client.

Ms Curran: Yes.

CHAIR: I will go to the member for Macalister for a final question.

Mrs McMAHON: A number of submissions talked about a peer workforce and those with lived experience. Amongst your members do you have any idea of the percentage of those who themselves have lived experience, identify themselves as peers in this area, and how important that is? We have had quite a few recommendations about mandating a percentage of workers within the sector to have that lived experience, so it would be incumbent on organisations to record that and their members to put their hands up and self-identify, which can be problematic.

Ms Curran: It is very difficult in psychology, because up until more recent times there has been a legal requirement to report your peers who might be impaired practitioners. That has become more flexible more recently so that, if you are getting treatment, that is a good thing.

Mrs McMAHON: That sounds like a horrible term, impaired practitioners. It does not sound very trauma informed.

Ms Curran: I think it possibly has led people to not getting help because they think, 'If I tell somebody that I'm depressed, I'm going to get reported,' but that is not the case so much anymore. We have not surveyed our members about lived experience, but I would be quite sure that there would be quite a percentage of psychologists who do have lived experience or have a family member who has lived experience.

CHAIR: It is quite a broad umbrella term, from what I understand, as well. You might have a non-clinically based conviction of some description, or you might have an alcohol and drug issue or you might have experienced domestic violence. It is a really broad, encompassing term.

Ms Curran: Yes.

CHAIR: Thank you both for your submission and for coming along and providing that evidence this afternoon. It has been most useful for the committee. It will certainly help to inform us as we go forward. I would like to thank all of your members for their work over the last two years. The pandemic has, no doubt, made it very difficult for the health professions. On behalf of the members of the

committee we are certainly very thankful for the work that you do. You have taken one question on notice. We would ask that you provide us with a response by the close of business on 18 March. I want to thank our secretariat for your support today; I also want to thank Hansard for your work today. I declare the hearing closed.

The committee adjourned at 4.53 pm.