



MENTAL HEALTH SELECT COMMITTEE

Members present:

Mr JP Kelly MP—Chair
Ms AJ Camm MP
Ms AB King MP
Dr A MacMahon MP
Mrs MF McMahon MP
Mr R Molhoek MP (virtual)
Ms JC Pugh 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

TUESDAY, 12 APRIL 2022

Brisbane

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The committee met at 8.58 am.

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

I would like to introduce the members of the committee. I am Joe Kelly, the member for Greenslopes and chair of the committee. Joining us via Zoom is Mr Rob Molhoek, the member for Southport and deputy chair of the committee. We also have: Ms Ali King, the member for Pumicestone; Mrs Melissa McMahon, the member for Macalister; Ms Jess Pugh, the member for Mount Ommaney, who is substituting for Mr Barry O'Rourke, the member for Rockhampton; Ms Amanda Camm, the member for Whitsunday; Dr Christian Rowan, the member for Moggill; and Dr Amy MacMahon, the member for South Brisbane.

The purpose of today's proceedings is to assist the committee with its inquiry into the opportunities to improve mental health outcomes for Queenslanders. This is a proceeding of the Queensland 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.

These proceedings are being recorded and broadcast live on the parliament's website. Media may be present and are subject to the committee's rules and the chair's directions at all times. You may be filmed or photographed during these proceedings and images may also appear on the parliament's website or social media pages. Please turn your mobile phones off or switch them to silent.

I remind all those who are watching the broadcast or reading the transcript to please seek support if today's hearing raises any issues for you. Contact details for support organisations are also available on the committee's website.

BREWER, Mr Peter, Acting Assistant Commissioner, Domestic, Family Violence and Vulnerable Persons Command, Queensland Police Service

CHAIR: I now welcome Mr Peter Brewer from the Queensland Police Service. I ask you to make a brief opening statement and then we will go to questions.

Assistant Commissioner Brewer: Thank you for the invitation to appear before the Mental Health Select Committee today. My name is Peter Brewer, and I am the acting assistant commissioner for the Domestic, Family Violence and Vulnerable Persons Command of the Queensland Police Service. I would like to start off by respectfully acknowledging Aboriginal and Torres Strait Islander people as the traditional custodians of the land on which we are meeting today and I pay my respects to them, their cultures and elders past, present and emerging.

The QPS is the primary law enforcement agency in Queensland. Our members respond to a wide range of calls for service, including calls from, or about, people experiencing mental health issues. More often than not, police are responding to people experiencing these issues at a point of crisis. When a person is at a point of crisis, providing an appropriate response is a complex and dynamic exercise. No two calls for service will be the same and police must respond to the circumstances that appear in front of them. With this in mind, the QPS guides our police officers through the training, policies and practices of the QPS, all of which have evolved over time as the best practice approach and are further continually developing.

As with any other response, when responding to mental health calls for service the QPS is led by its core values of integrity, professionalism, community, respect and fairness. As an organisation our decisions are driven by our strategic plan. Our current plan objectives include building a connected, engaged and job-ready workforce with the health, wellbeing and safety of our people as a priority and creating a safer community. Providing better services through connected and engaged

Public Hearing—Inquiry into the opportunities to improve mental health outcomes for
Queenslanders

relationships is also very important. We align our actions as an organisation with broader government policies, including, for example, the Shifting minds: Queensland Mental Health, Alcohol and Other Drugs Strategy Plan 2018-2023. There are three focus areas of that plan aimed at improving the mental health and wellbeing of Queenslanders.

One of the focus areas is the whole-of-system, which focuses on collective responsibility. The driving force in the QPS is to further our strategic objectives in the State Domestic and Family Violence and Vulnerable Persons Unit, which was established in 2015 and now sits within the command that I lead. The command has guided and shaped policing responses to a range of portfolio areas, including mental health and suicide prevention. The command provides specialist advice and enhances operational support and governance at state and national levels to help formulate appropriate frontline policing strategies and referral pathways for vulnerable people.

A key contributor of the ability for the QPS to meet its strategic objectives has been our ability to form partnerships across government and non-government agencies. The number of calls for services relating to mental health has increased year on year since 2016. As outlined in our submission to the committee, these calls for service have increased by about 58 per cent since 2016. In 2021 the QPS responded to an average of 976 mental health calls for service every week. Taking a partnership approach to mental health issues is vital for the QPS because it enables us to respond in an appropriate way.

Operationally, partnerships can take several forms. These are detailed within our submission. For example, our mental health liaison service is a very important aspect. It sees the QPS partner with mental health clinicians in the Brisbane Police Communications Centre to assist officers who respond to mental health related calls for service by giving them information that can be used when interacting with a person experiencing a mental health issue. We also have our Mental Health Intervention Program, which is a joint initiative with Queensland Health and the Queensland Ambulance Service. Our mental health coordinators and specialist police who drive service integration collaborate locally to promote interagency partnerships and responses. The QPS also has access to police and ambulance service intervention plans which are developed by Queensland Health and assist the QPS and QAS respond to mental health events in the community with non-mental health consumers. These plans include information such as: what to expect when attending; possible intervention strategies and techniques to de-escalate a situation; and contact details of support persons.

The Queensland Police Service operates eight Queensland Health and QPS co-responder models across Queensland. When responding to calls for service, a co-responder team generally consists of a police officer and a mental health clinician who provide an appropriate response that prevents harm to the individual and others, aims to resolve the situation safely and ensures only persons who are at risk are transported to an emergency department. Most co-responder models operate as a secondary response when the co-responder team attends an incident after a first response incident has been settled and it is identified that our service is required. There are currently two evaluations being undertaken on the mental health co-responder model and there have been two previous evaluations undertaken in 2016 and 2017. Generally, the evaluations found positive impacts such as improving the resolution of mental health incidents, enhancing interagency collaboration and improving the likelihood of a person avoiding hospital.

The QPS also takes the mental health and wellbeing of our people seriously. As I am sure you can appreciate, policing is an inherently dangerous occupation and both physically and psychologically challenging. First responders are twice as likely as the general population to experience a mental health condition. The Our People Matter strategy and the QPS wellbeing strategy are both targeted at ensuring the QPS has a safe, healthy and supported workforce. We strive to achieve a thriving workforce where our people can realise their full potential.

Thank you for the opportunity to appear before you today and assist the committee with its important work.

CHAIR: Thank you, Deputy Commissioner. I assume that your average general duties officer would receive some degree of training during the initial training period all police receive. Is there then ongoing training around how to respond to people, particularly in a mental health crisis?

Assistant Commissioner Brewer: The QPS always strives for a high level of training to all police personnel and is strongly committed to the provision of contemporary leadership while delivering a professional service with public value. There are several training packages the police undertake, but I would probably start with the police academy. The recruits attend mental health training via an online learning product which takes around 11 hours to complete. That is then followed up by a number of workshops over several hours to cement the learnings of the online learning

product. The learning outcomes include: defining mental illness, the legislation, potential causations of mental illness, identifying verbal behavioural and environmental cues for dealing with those incidents and applying appropriate communication strategies, all the way through to understanding how to take out an emergency examination authority under the legislation.

At the first year level officers receive ongoing training. It is face-to-face eight-hour training. This is meant to cement the learnings of the first year officer about mental illness, its prevalence, the appropriate language to use when dealing with those jobs, understanding the stigma involved with that sort of health condition, managing the legislation, and how to respond to those crisis situations. There are additional workplace activities first year constables are also involved in, and there are also additional courses the QPS offers to those who are interested and involved in those types of calls for service. That can be first responder crisis intervention training, a number of other online learning products and there are additional workshops that QPS undertake in regional areas in a joint agency joined up response with our partner agencies.

Mrs McMAHON: I want to look at some of the responses in relation to attending jobs. I note in the submission there were a range of jobs that were categorised as mental health jobs, whether they be suicide or attempt suicide, as well as 504 category jobs. We have heard from organisations in the field of suicide prevention that the data shows not everyone who attempts suicide or has a suicidal ideation actually has a mental illness. When attending a possible suicide attempt or ideation, what is the role of police when treating it under the Public Health Act and using potential emergency examination authorities? Does that then involve putting someone who does not have a mental health issue into a potentially traumatic situation and potentially escalating the situation? Can you comment on the role that police play in suicides where there is no clear underlying mental health issue and whether it is all treated as a mental health job?

Assistant Commissioner Brewer: That is a very complex issue. In general, when police receive a call for service it may be initially triaged as a possible mental health job, a suicide or an attempted suicide. Sometimes there is limited information depending on who provides that information and where the caller comes from. It might be the person themselves reaching out. Remembering, of course, that police are only part of the mental health system, in our response to people at a point of crisis we are guided by our operational procedures manual and other legislation as we attend those calls for service.

Police are very mindful that the action of taking an emergency examination authority is probably the option of last resort. Police will often respond with a co-responder model to attempt to provide de-escalation or, if there is an alternate pathway, to provide that person with a treatment option or return them to a care service by the least intrusive method. It is only at the point where people are actually at a point of violence, unable to be controlled or dealt with in another way that police will take that last effort to convey them to a place of safety.

Mrs McMAHON: We have data on the number of jobs police have attended to. Do you have any data on how many EAs have been taken out by police in responding to those jobs?

Assistant Commissioner Brewer: I do have that information; I just cannot locate it at the moment. Perhaps I could take that on notice.

CHAIR: Yes, you can take that on notice.

Mrs McMAHON: You mentioned the co-responder model. You said there are eight models currently in operation. Can you tell us where those eight co-responder models are currently operating?

Assistant Commissioner Brewer: There are currently eight Queensland Health and Queensland Police Service co-responder models operating across the state. They are currently operating in the Far North, primarily Cairns; Townsville; the Sunshine Coast; the Moreton area, the Caboolture area; Ipswich; South Brisbane; Logan and the Gold Coast. These programs are governed by a facilitated police district and hospital and health service arrangement—local arrangements—so the co-responders are responsible for monitoring calls for service, identifying when it is most likely they should be working and the availability of resources to attend those particular jobs.

Mrs McMAHON: You said there were evaluations already done on some of them.

CHAIR: We have received one for West Moreton already. It would be good to get copies.

Assistant Commissioner Brewer: I am aware of the previous ones in 2016 and 2017 referring to the Cairns and the Ipswich co-responder models. The learnings out of those helped shape the way we respond with co-responders into the future. Generally the learnings were that it certainly improved the resolution of mental health crises, getting to that escalation point and deescalating; it enhanced Brisbane

Public Hearing—Inquiry into the opportunities to improve mental health outcomes for
Queenslanders

the collaboration between ourselves, the Ambulance Service and Queensland Health; it certainly resulted in a greater likelihood that persons could actually remain in their own residence if the incident was identified early and dealt with appropriately; and it certainly improved the perceptions of the police by those persons, those particular clients. We also recognise there is a need for further evaluation to support consistency of practice throughout the state. Part of the role of our command is to actually capture those learnings and provide them to the rest of the state services.

Mrs McMAHON: Would we be able to get a copy of the two evaluations from 2016 and 2017?

Assistant Commissioner Brewer: I will certainly make them available if we have them. They may have been led by QAS and Queensland Health.

CHAIR: Before we move to the deputy chair for a question, I have one more question about the co-responder model. The places that you have listed are all fairly densely populated areas that would probably have reasonable levels of policing and health resources. How would the co-responder model be applied in areas that are not so heavily populated or are more regional and rural type areas?

Assistant Commissioner Brewer: You identify a very important issue that what we do here in the south-east corner of Queensland and in densely populated areas does not always apply in regional and remote areas. In those areas we rely on the police having a relationship with the joint agencies, whether it is the QAS or Queensland Health. Depending on where the place of safety is—usually the hospital—that will then centralise the way you respond to that particular area. We may not have a co-responder in place at that point in time but there is usually an established relationship that will support the best possible practice and be least intrusive when getting that person to a point of assessment.

Mr MOLHOEK: Assistant Commissioner, could you reflect on the difference between providing service on weekdays versus weekends? I ask that question because I know my local police command often faces significant challenges from about 3 o'clock on a Friday through to Monday morning as a lot of the service agencies and support people tend to pack up and go home for the weekend. Does the workload escalate on weekends? Is the rate of call-out higher on weekends than weekdays? What are some of the challenges that the police face in dealing with some of the call-outs over weekends, and evenings for that matter?

Assistant Commissioner Brewer: Where we have co-responder models available they will usually roster according to the peak times for service. We are usually able to deal with that because it is an anticipated and known incident. Where we lose control of the situation is sometimes when significant events occur and a number of people will be suffering an episode or a particular point of crisis. Sometimes the need for services exceeds what is available at that point in time. I cannot give you a general reflection other than anecdotally with policing: yes, on weekends it does usually get busy and not all services are available. However, usually if a person is a known client and is not at a point of crisis, there can be a referral made that is taken up through referral agencies within usually a period of a couple of days to deal with that situation. It is only if that person is getting to the point of crisis that we will then need to take immediate action.

Mr MOLHOEK: In the data that you have provided on mental health calls, is there any data that breaks it down perhaps by the day of the week?

Assistant Commissioner Brewer: I do not have that available, but if it is available I am happy to give that to the committee at a later point. Can I take that on notice?

Mr MOLHOEK: Thank you. The other part of that question is about the service calls. I think the report says there are about 50,000 a year, which is about 140 a day. What is the average amount of time and how many officers would be involved in each of those service calls? They get the call, they respond and perhaps have to escort the ambulance or the family to a mental health facility or a hospital. I am wondering how much time is actually consumed on average for each of those calls? What is the full-time equivalent amount of time on an annual basis that that demand places on the police force?

Assistant Commissioner Brewer: I can probably only provide anecdotal reflection to that particular question. There is no median data about how long a particular incident will take. There are many variables in that situation, being the geography of where the person is experiencing that situation, how far they are from a hospital or health facility, the availability of police or ambulance, the point of crisis that the person might be in, if they can provide self-care, whether they can go in an ambulance or if they are at a point where we actually need police intervention. Once you actually get the person to that hospital or health service facility it then becomes dependent on the availability of Brisbane

Public Hearing—Inquiry into the opportunities to improve mental health outcomes for
Queenslanders

an appropriate clinician to assess that person. Sometimes the police will have to wait with that person until that point of assessment so, in general, it can take a short time or it can take a long time. That is probably as specific as I can be.

Mr MOLHOEK: Is there any data collected on that? Would there be more information available within the system, without creating too onerous a burden of going and getting it? It would be interesting to know how much police officer time is consumed or used addressing mental health issues. Also, given some of the challenges within our health system and some of the challenges with being such a vast and remote state geographically, there must be occasions where there is a lot of time involved. I am wondering if there are other models of care or support available that do not require taking police out of service for too long.

Assistant Commissioner Brewer: As far as the time available, I am unsure if that is able to be provided but I will certainly look into it and can report back. An explanation that I might be able to offer is that the number of calls for service we receive is around 976 on average per week. The most frequent event is an attempted or threatened suicide and there are about 644, on average, of that 976; people experiencing a mental health condition is 255; and an authority to return a person is only 70. The majority of our work tends to sit into that attempting or threatening suicide. Not all of those people will require further intervention from police. If we can respond to that person appropriately at that time and at that place, it might be deescalated and there is no further need. By way of the average week and the busiest areas, naturally south Brisbane, the Gold Coast and north Brisbane and even the far north are probably some of the busiest areas in that regard.

Ms CAMM: Assistant Commissioner, can I express my thanks to the Queensland Police Service. I think that your evidence is actually some of the most important that we will hear in this committee work because you truly are at the frontline acute space of mental health and your data demonstrates that. To clarify the data, my question is around attempting or threatening suicide or mental health and whether that also encapsulates domestic and family violence data? Is there an overlay at all or is it captured in the one? In a domestic and family violence setting where you may have one person threatening suicide or there may be consequences of mental health, is that categorised separate to this or is it also encapsulated potentially within this data?

Assistant Commissioner Brewer: I think you will find that it is probably blended data. The primary call for service that will require police to attend will often be a domestic issue with an underlying issue of alcohol or drugs or it might be a mental health episode. The way that would be classified is primarily a call for service for domestic and family violence. It may be hard to unpick that data.

Ms CAMM: That is fine. That helps in my next line of questioning. I note your co-responder model. Anecdotally, the conversations, in my experience, particularly in North Queensland, when there has been a significant demand on the Queensland Ambulance Service as well as other emergency services is that there is an increased risk for police officers when making the choice to transport patients or if the co-responder is already tied up officers are making a call as to how they respond. Is that something that the Queensland Police Service is aware of and has any concern about, given the growing demand that your statistics point to, and is that concern about putting officers at risk, say, in the worst case scenario of a potential death in custody or just in regards to taking officers away from the primary function of law enforcement?

Assistant Commissioner Brewer: I think I understand the question and I am happy for it to be clarified as we go. I think the question mainly revolves around the resourcing of police and if we are sometimes called to do things that might be the job of another agency. There are occasions when that will actually happen. There is always tension in any regional area or even in an urban area around the resources that are available. Sometimes the Queensland Ambulance Service will be tied up and there will be no units available so the police will then have to make a choice about how we intervene in that situation. The underlying and the most important thing that we do is keeping the least intrusive method for that person experiencing that episode at the forefront of what we are trying to do, realising the stigma that is involved in being transported by a police vehicle. We will explore other options. There might be a family member who can help in the transport, accompanied by police, or other ways of doing things.

As I said earlier in my evidence, the last thing that police want to do is take out an emergency examination authority and have to restrain someone and take them to a hospital or a healthcare facility. If we can resolve it in another way then we will. But often with the training that we have we can deescalate the situation sufficiently that people will be reasonably happy to accompany the police

Public Hearing—Inquiry into the opportunities to improve mental health outcomes for
Queenslanders

and they will do the transport to a health facility if that is what is required. But sometimes, as I said, there are tensions in relation to resourcing. What we also encourage in each particular district is interagency collaboration so they can actually talk about those resourcing issues. They can talk about ways of overcoming those calls for service peaks. Our command actually helps facilitate a number of regional workshops where we bring best practices to that or look at whether there are other ways or new ideas on how we can resolve those situations.

Ms KING: Assistant Commissioner, I join with all of my colleagues in thanking you and the officers who work every day to help address the mental health needs of Queenslanders. I have a question about the number of nonclinical or subclinical crisis support spaces that have been rolled out by this government. As a committee we visited the Oasis crisis support space in Hervey Bay, which is adjacent to the hospital. Can you speak to any issues for your officers in responding to mental health issues when transporting people or assisting their transport to one of these less clinical settings? Is that something that is flagged as problematic or that creates issues under your legislative responsibilities?

Assistant Commissioner Brewer: Probably in general terms we come back to the tension of resourcing availability. Not all hospitals are modern and they do not always have an immediate place of safety where you can put someone if they are at that point of crisis. Often if police are required to do a transport then they will remain with that person at the hospital or healthcare setting because there may be no available security or there might be an overriding public health need to remain with that particular person. In some facilities there are very good facilities where you can actually wait out of view, but that is not always the case. Sometimes police are forced to wait outside the hospital, even in a police vehicle, with the person until such time as a space is made available for that person to be assessed. In general terms, in the ideal world we convey people or assist in the transport to a facility but we often have to remain. There are places that do have less intrusive areas and waiting areas, but sometimes with the resourcing they too are consumed. It is a case-by-case basis.

Ms KING: I understand that not all of the episodes in which police intervene and take somebody to a health or mental health setting involve a compulsory examination order. In those situations where that has not been invoked, can you give us your views on the interface between QPS and less clinical settings? Is that something that in your view officers would welcome having more access to in terms of transporting people and providing them with a supported setting?

Assistant Commissioner Brewer: Yes. In the ideal world that would support that least intrusive option for the treatment of that person, be that transportation by the police, Queensland Ambulance Service or even a self-referring person going to that facility. We would certainly welcome any opportunity to expand that service provision and the availability of safe and secure areas for people experiencing episodes. That would certainly ease some of the resourcing.

Dr MacMAHON: My question is in relation to the submission made by the Public Advocate. He states—

A Queensland Police referrals service has been established ... to support vulnerable people in the community rather than in emergency departments, however it no longer includes a state-wide mental health service provider.

He suggested this was due to a lack of funding for that service. Are you able to comment on this?

Assistant Commissioner Brewer: I am not aware of the specifics of that, but in general I welcome the opportunity to talk about the police referral system. There is not a holistic state entity that accepts mental health referrals. There are a number of obviously funded and non-funded organisations that have opted into the police referral system so frontline officers can connect those people who are at risk or vulnerable with those external support services. Obviously that is by the consent of the person or if a person is under 16, it has to have the consent of a parent or guardian. Our service providers nominate the catchment area in which they are available to provide services. There are a number of mental health service providers for both adult and youths within the table that I have.

In general terms, the categories of referral would be mental health or sudden death support, suicide prevention or support for youth. There can be people who provide that as a subsidiary of another service because often there are multiple conditions that the person would be experiencing.

Dr MacMAHON: The Public Advocate also mentions that police officers do not receive mental health crisis training, and you have talked a little bit about training. Is this the case? If so, what consideration has been given to mental health crisis training?

Assistant Commissioner Brewer: Training is very important to us, too, realising that it is a contemporary thing and we need to continually improve. With the baseline training that officers get at the recruit stage at the academy at the first year officer level, those who opt into the role of the mental health intervention coordinator—we call them HICs—are offered a level of extra support and training to understand the environment they are in and how to work with partner agencies. More importantly, when police are responding at the point of crisis we receive ongoing face-to-face training each and every year about practising our skills, de-escalation and communication. It is actually included in our operational survival training. There are scenario based activities.

In actual fact, this year's scenario that we are working with is an incident that happened in Purling Brook Falls in North Queensland. It is very real training because it uses actual body worn footage and other things to bring the lived experience to that training. Officers will discuss the scenario, they will talk and they will practise the de-escalation techniques that are required in what we call the Behavioural Change Stairway Model. That is what we try to employ in those situations.

It is something that we are very conscious of and are always trying to do better in our training area.

Dr ROWAN: Thank you for the work that you and all QPS officers do. On behalf of all the committee members, I acknowledge the contribution by the QPS, particularly during the severe weather and flood event earlier this year in 2022. We thank you for that work. In your opening submission you talked about increasing calls for occasion of service since 2016, and there was a comprehensive review of the Mental Health Act with it being brought into being in 2016. Are there any comments, concerns or recommendations into how that is functioning not only with respect to emergency examination orders but also forensic mental health orders? In terms of the actual practical operation of the act and the QPS being asked to fulfil certain aspects of that, what have the impacts been for the QPS?

Assistant Commissioner Brewer: I might talk about that in general terms as well as the fact there is obviously an absent without authority aspect of the act that sometimes will involve or not involve the Queensland Police Service. We sit on a number of working groups dealing with that particular issue. That covers people who abscond from an institution, whether through transport or other arrangements, and a decision has to be made about whether to bring that person back.

Police will usually only be asked to assist if there is an authority to transport that person back to a facility. Often there is a tension around resourcing and who can get that person and bring them back if they will not come back on their own. That is sometimes a bit of a tension within the act and within the service provision space.

Dr ROWAN: I have a question based on what the member for Whitsunday was asking earlier. Ambulance ramping has been a topical issue in the public domain. Has ambulance ramping had an impact on the Queensland Police Service responding to occasions of service for mental health concerns in Queensland? If so, what has that impact been?

Assistant Commissioner Brewer: I can talk in general terms. Obviously surges in the emergency department can result in significant delays in the assessment, treatment and care of the person. I have alluded to this previously and certainly within the broader healthcare sector we realise we are a part of that process. There can be delays of many hours at times where police have to stay with that person until the point they are actually assessed, and that does take them off the road. They are effectively ramped at a hospital for that period of time. We are fortunate enough that we usually have more than one unit out there and we will reallocate jobs as necessary. Certainly, the quicker we can get people back into the operational environment, the better. It is a bit like the Ambulance Service, we are affected by ramping issues.

CHAIR: The federal Productivity Commission has recommended that planning for mental health services be pushed down to the lowest regional level possible involving PHNs and the health and hospital services. Would Queensland Police see a role for police to be involved in consultation, at least around the development of some sort of regional planning for mental health services?

Assistant Commissioner Brewer: There are a number of governance committees that the Queensland Police sit on at the moment. The primary one is probably the Tri-Agency Mental Health Steering Committee. We are an equal partner in that along with Queensland Ambulance Service and Queensland Health. We have a number of members who are represented on that. That has a number of subsidiary working groups down to district and regional levels.

Our contribution to the tri-agency is by way of the policy procedures, even dealing with other aspects around fixated threat assessment of persons in that group towards perhaps members of the public or even public officials, dealing with the impacts of police referrals and what is happening in that space, drug and alcohol issues, and also police communication calls for service. We have a very

big role in that particular steering committee which then devolves down to local areas. We obviously will share information and bring problems that cannot be resolved at a local level to that tri-agency committee.

CHAIR: The other question I have in terms of planning and service development is there is a real trend and a push for people with lived experience to be involved in the planning and development of mental health services. Has there been work done in the Queensland Police in terms of engaging with people with lived experience around the way police respond to and manage people who are particularly in crisis?

Assistant Commissioner Brewer: I do not have the information immediately available, but I do know with part of the training that we are developing and certainly in the regional workshops we do have a role for clinicians, specialists in the area and also people with lived experience because that provides valuable learning to us at the front line about how to deal with people and how to recognise what is important to them. Part of our holistic approach to training is incorporating lived experience, whether it is about mental health or any other particular issue that police deal with.

Mrs McMAHON: In wrapping up, I wanted to look at the wellbeing of QPS members, both sworn and unsworn. I note in your submission and in several submissions that we have received the rate of mental health conditions for frontline responders far exceeds that of the general population. I know you have the Our People Matter strategy, which has been going for a while now. Could you comment on the work around the stigma of mental health, particularly within organisations like the QPS and the real or perceived impact on members with mental health conditions in terms of career? What concrete things are being done within the QPS to assist those members who do come forward or who would like to but are too scared?

Assistant Commissioner Brewer: When you are dealing with strategies around your workplace there are always challenges. I know the member is very well aware of the Our People Matter strategy. It is certainly something that stands at the forefront of how we underpin and respond to our organisation. Probably more important is the fact that with workers compensation laws there is a recognition of PTSD for police officers so that, like first responders, we do not have to go and prove the fact that we have had exposure to that. There is a presumption, which is a very helpful thing when you are trying to get effective and timely treatment for officers who identify.

In terms of the stigma around mental health, we work on that every day. Some of the things that we are doing now under the Our People Matter strategy include the local champions in each particular district. They can sometimes be junior officers or, more importantly, senior officers who will go and talk about their lived experience with mental health. When they have the openness and willingness to stand there and share amongst their peers about situations or episodes that they have encountered and how they have had to deal with that, it brings that lived experience and the fact that people do not feel isolated anymore; they feel they can reach out. Part of the strategy, very importantly, is the ability to connect people at different levels, whether it is a peer support officer just for support or a range of referral options to professional people. There is also the ability to access services outside of the Police Service for those members who are still hesitant to actually disclose. The most important thing is that they receive support in that space.

While the strategy has been around for a little bit of time, it is certainly ongoing. It is very important and it underpins the work we do with our own officers.

Mrs McMAHON: Post service—you have spoken about the Our People Matter strategy in terms of people who are currently in service. However, you and I have probably been to far too many funerals of people who have suicided post service. We had a submission from Stand for PTS in relation to a proposal for an organisation for frontline responders similar to the DVA which would specifically care for people post separation. What do you see the QPS's role would be for someone post separation to prevent this tragedy?

Assistant Commissioner Brewer: Yes, I, too, echo your sentiments. Through safety and wellbeing we are looking holistically at deliberate strategies to engage members in that post-separation situation. Whether people retire or medically exit the service, we are trying to develop a number of processes for people to opt back in so they can still remain connected to the workforce. Often we find the biggest barrier when people separate from the QPS is that sense of belonging and family, and that really underpins and magnifies the effect of what they are experiencing. We are making very firm efforts to have deliberate engagement strategies in the regions and districts.

Dr ROWAN: I just wanted to ask around illicit drug diversion initiatives whether there are any recommendations the QPS would provide with respect to anything further that can be done in that area?

Public Hearing—Inquiry into the opportunities to improve mental health outcomes for
Queenslanders

Assistant Commissioner Brewer: Obviously you are aware of the current government policy which will offer a diversion for minor drug offences—obviously for cannabis and utensils—with a prelude to the fact that they have not committed an indictable offence and have not served a term of imprisonment. We find that that is operating successfully. We are aware that there are always improvements or things that can be done in that space. Obviously, if the policy were developed we would stand ready to implement that. Last year there were 6,128 people successfully diverted under the diversion program. More importantly, police picked up about 2,600 additional people whom they were able to identify at the point of dealing with them and offer them a diversion support program.

CHAIR: Assistant Commissioner Brewer, thank you for your presentation today. You have taken a number of questions on notice. We require responses to those back by the close of business on Tuesday, 26 April. On behalf of the committee, I would like to thank you for your evidence today; it has been very useful. On behalf of the committee, I would also like to thank all members of the Queensland Police Service for the work they do, and particularly have done during the last 2½ years of COVID. I think all members of parliament would have had to call on the police at various stages to assist with issues around mental health. I certainly had the experience of seeing police officers deal with a mental health crisis and I was absolutely in awe of the professionalism that they showed. Thank you on behalf the committee.

Assistant Commissioner Brewer: Thank you, Chair and committee.

COX, Ms Yasmin, Executive Director, Specialised Health and Safety Services, Office of Industrial Relations

DEAKES, Ms Jodie, Executive Director, WHS Engagement and Policy Services, Office of Industrial Relations

HILLHOUSE, Ms Janene, Executive Director, Workers' Compensation Regulatory Services, Office of Industrial Relations

JAMES, Mr Tony, Acting Deputy Director-General, Office of Industrial Relations

MAXWELL, Ms Karina, Senior Social Worker, Workers' Psychological Support Service

REVILL, Ms Marnee, Social Worker, Workers' Psychological Support Service

CHAIR: I welcome our next group of witnesses from the Office of Industrial Relations and the Workers' Psychological Support Service. Before we go on, I would like to declare a conflict. Karina Maxwell and I were involved in a First Nations reconciliation group in the electorate of Greenslopes and I also asked Karina to MC a mental health community forum we held a number of weeks ago. I invite each organisation to make a very brief opening statement, after which we will get committee members to ask some questions. Who would like to go first?

Mr James: I won the toss. My colleagues and I welcome the opportunity to appear before the Mental Health Select Committee today. I begin by acknowledging the traditional owners of the lands on which we meet and we pay our respects to elders past, present and emerging.

In partnership with stakeholders, the Office of Industrial Relations works to achieve Australia's lowest rate of work related and electrical fatalities, injuries and disease; to improve rehabilitation and return to work outcomes; to deliver balanced workers compensation regulatory services; and to provide a framework for fair and productive industrial relations in the Queensland IR jurisdiction, contributing as a partner in the national workplace system. As deputy director-general, I am also the workplace health and safety regulator and the workers compensation regulator.

Workplace Health and Safety Queensland is a division within the Office of Industrial Relations and is responsible for the administration of the Workplace Health and Safety Act 2011. The object of the Workplace Health and Safety Act at section 3 is to provide a balanced and nationally consistent framework to secure health and safety for workers and workplaces. Section 3(1)(a) states that it achieves this by 'protecting workers and other persons against harm to their health, safety and welfare through elimination or minimisation of risk arising from work'. I will not be quoting any more legislation in my introduction. This includes risks to psychological health and wellbeing. To meet the objects of the act, Workplace Health and Safety Queensland enforces the workplace health and safety laws, investigates workplace fatalities and serious injuries, refers matters to the independent Office of the Workplace Health and Safety Prosecutor and educates and provides guidance to employers and employees on their legal obligations and how to improve the workplace health and safety outcomes for both physical and psychological health and wellbeing.

As the workers compensation regulator, I have oversight of the Queensland workers compensation scheme. It is independent of WorkCover Queensland and independent of self-insurers. With the Workers' Compensation Regulatory Services within OIR we seek to ensure a fair and efficient scheme that balances the needs of employers and employees, monitor the compliance and performance of insurers, decide self-insurer licence applications, support the efficient administration of medical assessment tribunals and undertake dispute resolution such as reviewing insurer decisions and managing appeals against the regulator.

OIR's dual regulatory role in work health and safety and rehabilitation and return to work means we work across the continuum of promotion, prevention, early intervention and recovery from work related injuries. This puts the Office of Industrial Relations in a unique position to influence mentally healthy work in Queensland, while ensuring workers who do suffer a work related mental illness have the right care and support to recovery.

Our submission to the inquiry noted that psychological injury claims make up only 2.7 per cent of all accepted claims, but they represent 9.1 per cent of total statutory payments—\$118.6 million in 2021—with average finalised lost time claims more than double that of physical claims, and that is trending upwards. Overall, there has been a 78.2 per cent increase in accepted psychological claims

in the last five years. There have also been increases seen in the number of claims lodged. It is anticipated that that trend will continue. It is expected that there will be about a 9.5 per cent increase in claims lodged this financial year.

This is not unique to Queensland. From 2000 to 2018, the number of claims for psychological injuries in Australia increased by 51 per cent and by 2018 psychological injury claims accounted for 68 per cent of all disease related claims. Nationally, the shift is understood to be impacted by a number of factors, including the changing nature of work, a shift in community understanding and expectations around mental health and wellbeing, and prevailing conditions across the economy. As I mentioned earlier, psychological injury claims cost more than double that of physical claims due to workers being off work for longer.

Due to their complexity, these claims are also challenging to determine and are more likely to fall into dispute. They comprise over 30 per cent of the reviews of insurers' decisions by the workers compensation regulator. Psychological injury impacts the lived experience of workers and their families. These injuries are also felt across the health system, the economy and the community through loss of productivity, income and quality of life.

Queensland's workplace health and safety legislation places a positive duty on employers to foster psychological health at work and to manage the risks associated with exposure to work related psychological hazards. Psychological hazards include event based hazards such as sexual harassment and cumulative hazards such as unmanageably high workloads. Investigation of psychosocial hazard complaints is always complex—often more so than the investigation of a physical hazard complaint.

Our regulatory approach is focusing on harm prevention, health promotion and good work design. We focus on a continuum of prevention, early intervention, supported recovery and promotion. In this vein, initiatives that we are engaged with or have created which may be of interest to committee include Australia's first digital psychosocial risk assessment platform, the People at Work, which offers a free survey, resources and nation-leading indicators for mental health at work. This is national initiative led by Queensland for the benefit of all working Australians. We have the mentally healthy workplaces toolkit which provides support and tailored resources to employers and managers with clear, practical compliance information to systematically manage work related psychological hazards and risks. We are developing a code of practice for managing the risks of work related psychological hazards. This code will provide legally enforceable minimum standards for duty holders. That will make this code the first of its type in Australia. OIR is delivering on the Queensland government's commitment to investigate a sexual harassment code of practice.

If a worker is injured we know they can face challenges simply navigating a new or unfamiliar administrative process to get the support they need and recover and return to work. We know that the longer a worker is off work due to a work related injury, the likelihood of them returning to work diminishes. Over the last five years, the Queensland government has implemented changes to make Queensland's worker compensation scheme more accessible for workers with psychological injuries and to improve the workers compensation experience for workers. It has changed the definition of psychological injury by removing the qualifier that work needs to be the major significant contributing factor. This aligns with the test for a physical injury. Mandated insurers are to provide no-fault early intervention treatment and support for psychological injured workers.

CHAIR: Mr James, I will pull you up there because we are going to run out of time for questions. Can I go to Ms Maxwell for a very brief statement?

Ms Maxwell: Thank you for inviting Marnee, who is day 2 today, and I along. I am not going to ask Marnee to speak. I run the Workers' Psychological Support Service. It has been running for about three years. There is a lot of information in my submission around that. As it stands at the moment, there have been over 1,900 workers who have contacted the service. I am a social worker. I should say too that I acknowledge the traditional owners of the land that we on, the Turrbal and Jagera people. I am a Ngugi woman myself from Quandamooka. This service basically captures people who fall between the cracks. There is a lot of confusion when they contact me. As Tony was saying, they do not know the mental health system and what is going on. I very strongly advocate for the workers who come through my service.

CHAIR: You mentioned the code of practice that is being developed with legally enforceable minimum standards. Will that require legislation to go through parliament?

Mr James: I will turn to Jodie Deakes who is leading that development.
Brisbane

Ms Deakes: No, it will not. It will need to go through a cabinet process and it will need to go through our minister. It does not need to go through a parliamentary process. What will occur, however, is that any changes in the regulation in the future in relation to psychosocial hazards will have to go through parliament.

CHAIR: The OIR has funded a number of services like the Workers' Psychological Support Service. We visited the Mates in Construction, which I think you fund as well. Do we need to expand the support for employers to be more proactive in terms of promoting mental wellbeing and that suicide prevention role that Mates in Construction seems to play?

Mr James: Certainly, yes, we do support Mates in Construction with an annual grant, and we also support an administrative grant to mental health services, so that is very good. Chair, as I said, promotion is a key part of our fundamental operation. No public servant would ever knock back funding for matters, but I believe that we are funded to provide a number of initiatives that do support small and medium businesses, as I mentioned, for managing mentally healthy workplaces. The People at Work initiative, I have to say, Chair, is an outstanding Australian groundbreaking initiative that does support workplaces to take control, and employees and workers to have an understanding and a participation in building mentally safe workplaces. I will turn to my colleagues if they wish to mention any particular initiative.

Ms Hillhouse: I will clarify that in addition to the Workers' Psychological Support Service, we fund a number of advisory services, and one of those advisory services is undertaken by the CCIQ. It provides support to employers going through the workers compensation process.

CHAIR: My next question may be too specific to answer here. It refers to submission No. 19 from David Murray. Mr Murray outlines his and his family's experiences of the unexpected and sudden death of a teenage child and raises issues in relation to bereavement leave post the death of a child or a teenager. I am wondering whether or not the OIR could have a look at that submission and provide some guidance to the committee around how we currently manage bereavement leave in those situations and whether improvements can be made.

Mr James: I am not in a position to talk specifically about that matter. I cannot say that I am aware of it firsthand, however, I will undertake to have a look at what we can provide back to the chair on that matter. As you know, bereavement leave is an industrial entitlement in most state and federal awards. Also I believe it may be a national employment and a Queensland employment standard. I will provide what I can back to the committee on that matter.

CHAIR: I know from my time working at the Queensland Public Sector Union, the late Brian Mann did a lot of work around the capacity of First Nations people to attend to sorry business that did not quite fit into our three-day industrial leave, so there is some precedent there, I think. I will go to the member for Southport and deputy chair for questions.

Mr MOLHOEK: Thank you to all of you for appearing today. I do not know if this sits within your remit, but I will have a go. I note in the submission you have responsibility for overseeing workers who have been exposed to things like bullying or violence from clients and sexual harassment. It is my understanding that you also have a regulatory role or an oversight role with Workers' Compensation Regulatory Services in Queensland. Is there any work that you do that looks at mental health issues or mental anguish that is caused to clients who are waiting around for their workers compensation matters to be resolved? They may be off on a work related injury that is not necessarily related to bullying or violence or mental health, but then suffer anxiety which is created as they navigate the system and sit at home for months and months and months, if not years, waiting for cases and specialists, lawyers and everyone else to sort out their issues. Do you do any work in that space around mental anguish and mental health?

Mr James: I will turn to Janene Hillhouse, the Executive Director of Workers' Compensation Regulatory Services, but I would say that with regard to the waits for months and months, we have some fairly good information on case progress times.

Ms Hillhouse: It is very much recognised that mental health claims are more complex. There are a number of different variables that increase that complexity which means that the wait times are longer. Some of that can be because the causes of mental health injuries can be variable and they can result from a number of different factors. It can often take a little bit of time to understand the cause of somebody's injury. From a scheme-wide perspective, we have recognised that, and in 2019 we introduced a legislative change that means that insurers are able and required to provide workers with support services while their claim is being determined. We know that around 53 per cent of workers take up that option from insurers and access those services. It was also the reason the Workers' Psychological Support Service has come into being. It was really around making sure that

we were able to provide workers with getting access to the supports they needed, both before, during and after a claim. That service is very unique in a sense that you do not need to have a workers compensation claim to access the Workers' Psychological Support Service.

CHAIR: It looks like Ms Maxwell has something to contribute.

Ms Maxwell: Yes. With the over 1,900 people who have come through this service, they are quite often people right at the start of their claims or usually at the end. My aim is to contact people within two days and link them with counselling within two weeks. In the meantime, as a trained social worker, I provide them with some tools to work through the anxiety and to look after themselves, be kind to themselves, those kinds of things, depending on the worker and what is needed. I will gauge that. The reason for a second social worker now is to follow up with these workers as well later on. That is where I come into it. It is very unique to Queensland. There are other areas that are looking into this, but at the moment it is the only service in Australia, as far as I know, and it is only for Queensland.

Mr MOLHOEK: I think that is excellent. I wonder if—I think you touched on the time frames around case progress, Tony—the lengthiness of that and the delays in the system is probably causing greater mental anxiety, stress and depression for a lot of workers compensation clients than the original injury or challenge. My question is: is the workers compensation system good enough? Is it responsive enough? Is it timely enough? Is the fact that it is failing to be timely and effective in fact creating greater issues for people with genuine work related claims?

Mr James: Thank you for the extension of the question. I would suggest that no system is perfect. However, we are working well with this system and it offers support to injured workers. It has certain guidelines around processing of matters, particularly in terms of the review time lines. When an appeal is made against an insurer's claim, I am bound within certain guidelines to respond within certain times, which I can provide to the committee.

Mr MOLHOEK: In respect of the number of people who had taken up the support service, that service would also come at a cost to the client. At the end of their workers compensation claim, if there is a settlement or an ongoing agreement, would the cost of that service be taken from their final payout?

Ms Maxwell: The service is a free service because it is government funded and it is independent and confidential. There is a requirement for me to report to Industrial Relations but I keep only de-identified information. It is a free service.

Mr MOLHOEK: Other services around mental health support and counselling and psychological assessment, and from psychiatrists—they are all deducted from the final agreed settlement, are they not?

Ms Hillhouse: Yes, that is correct, yes.

Ms KING: Thank you so much for being here today. I will follow on somewhat from the questions put to you by the member for Southport and ask you to unpack those issues a little bit further. My own experience of a severe workplace injury some years ago—and, I will note, not under the Queensland scheme—was that no meeting with my case manager seemed complete until I was in tears, and that was a severe physical injury. I wonder if you can provide any information about what we know of the mental health risks of perhaps even a physical workplace injury? You did touch on it, I acknowledge, but could we have any further information about that?

Ms Hillhouse: Are you more interested in understanding the risk of physical injuring turning into a—

Ms KING: What do we know about the secondary mental health impact of a physical or a non-mental health injury at work?

Ms Hillhouse: We know that secondary mental health claims are rising. They are rising quite considerably, up to 32 per cent in the last five years. They are now equivalent in terms of active claims within the scheme to primary psychological injuries. That sits around the 2,000 to 3,000 mark in terms of accepted claims. They also are far more complicated.

Mr James had mentioned all of the different statistics around the time and the cost of workers compensation claims for psychological injuries. When it comes to secondary psychological injuries, those statistics actually change. The duration of claim doubles again, so you are looking at average durations of around 302 days. Obviously the cost then doubles again and the chance of a return to work actually diminishes as well by another 15 to 20 per cent. We do understand that it is an area where we are seeing far more impact within the workers compensation scheme and it is something that my health and safety colleagues might like to comment on, more from a risk perspective.

Ms Deakes: We do not want people to end up with an injury or illness. Part of our mandate in the health and safety space is wanting to make sure our standards are really set and clear and understandable through our legislation, our codes and our guidance, so that there is information there to try to prevent the injury before it occurs.

In terms of the secondary psychological injuries, we know a lot is linked back to musculoskeletal disorders. In relation to that, we have a number of initiatives that are targeting musculoskeletal. If we can prevent and reduce those, the likelihood then of moving into a secondary psychological injury will also be reduced.

In the prevention and policy space, we have a very big role in terms of managing that risk, informing employers, educating them, but also when they are not managing their risk, that through our inspectors, we can also investigate and enforce when needed. The dual benefits of that are: one, there is a clear message to the community that you need to manage these risks; and secondly, it is about holding those employers to account as well. Generally speaking, our prevention is very wide in terms of how we target that and our aim is to stop that injury from the very beginning.

Dr ROWAN: Thank you to the Office of Industrial Relations, and the Workers' Psychological Support Service. It is certainly a complex and challenging public policy area that you all deal with. Deputy Director-General James, my question is in relation to the access and availability of services for injured workers, if they have a primary work related psychological injury or, as some of the other members have alluded to, a primary diagnosis and secondary mental health comorbidity. Throughout the hearings of the Mental Health Select Committee there has been a lot of discussion about access and availability of services, particularly with respect to psychologists and psychiatrists and other service providers in different parts of the state; from a geographical perspective, what exists in South-East Queensland is not the same as what exists in Rockhampton or Mount Isa or other places in Queensland because of workforce.

I want to get a sense of the availability of the health workforce to provide services to injured workers and whether you have seen any trends because of COVID. We know there has been a greater mental health burden which psychologists, psychiatrists and others are treating. As a specialist physician, anecdotally what I am hearing from psychiatrists and psychologists is that there is more need for them to be providing those services, let alone what is needed for compensatable work-related psychological injuries.

Mr James: Yes, anecdotally I am hearing exactly the same. Since COVID there are a number of factors and features which are challenging the mental health of many people, let alone workers. I am going to turn to my colleague again, Janene Hillhouse, who may be able to provide more detailed data in response to your question.

Ms Hillhouse: From the work we do with insurers, we very much understand they are facing the same challenges. Workers continue to experience long wait times to seek treatment and diagnose, so it is a challenge that is being seen across the workers compensation scheme as well. Often, as was spoken about earlier, it is something that can be a significant source of uncertainty, prolonged recovery and frustration for workers and employers as well as insurers because they are unable to progress the claim or progress a worker's recovery as quickly as would be optimal for a worker to return back to work and recover as soon as possible to get on with their own lives.

In relation to COVID, the thing we have seen is that there has been a greater uptake in telehealth. We do know from WorkCover that around 30 per cent of their psychiatry consultations are done by way of telehealth. From the perspective of our own services, we provide secretariat support to the medical assessment tribunals. We have introduced virtual medical assessment tribunal hearings, and they now count for around one in three of our medical assessment tribunal hearings. The scheme also does recognise the fact that there can be challenges in terms of workers in the regions accessing certain services. A worker is supported in terms of their travel costs while they are on a workers compensation claim to access the services they need to improve their recovery.

Dr ROWAN: Without leading you into a particular answer, is health workforce availability or lack of availability delaying the progression of some claims or the finalisation of them? As the member for Southport alluded to earlier, is it the case that people may have their claim delayed because they are not able to see a psychologist or psychiatrist because there are other emerging issues? In other words, if there are any delays in those claims being finalised or concluded, is it because there is a lack of service providers or psychologists or psychiatrists to provide such services?

Ms Hillhouse: I do not have any hard data to support that. All I can say is what anecdotally we have been made aware of.

CHAIR: Ms Maxwell, does your service receive many calls from people under the age of 18?
Brisbane

Public Hearing—Inquiry into the opportunities to improve mental health outcomes for
Queenslanders

Ms Maxwell: Very few. There are some. Sometimes parents ring for their children as well.

CHAIR: In terms of the workplaces that people contact your services from, is there a broad spread? Is it large organisations, Public Service, private sector, small business? What is the mix there?

Ms Maxwell: It is pretty much all of them. In saying that, there are fewer from emergency services and defence because they have really good structures already. It is pretty much everything else though.

CHAIR: You said that you contact people within two days and try and refer them on for counselling services. In the current situation do you find there are difficulties or challenges in referring people on for psychological or counselling support?

Ms Maxwell: Yes, absolutely. Most would be telehealth. Some people would prefer face to face, and that is when it can be a challenge. Since COVID it has been so much easier to link people into telehealth options. It is also the type of counselling. There is NewAccess and a few others that have short-term counselling. That is free as well and it is great, but sometimes they need a little bit more in-depth counselling and support. Everything has its place. It is matching the worker with the right kind of counsellor as well. It is kind of like an intake role a little bit, but I am working with workers.

Ms CAMM: My question is probably to Ms Deakes and Ms Cox and it relates to legislation for psychosocial hazards. Recently I have had two women—but I do not want to say it would only be women—come forward who work for large government organisations in the HHS setting. In one case the woman actually ran into her ex-husband—a perpetrator with a domestic violence order—who has also been employed by such a service. When they have gone through the HR process the response has been, 'There's nothing that we can do about that. Maybe you need to find another job or maybe you need to work out a safe plan.' I would consider that being confronted and having to relive trauma is potentially a psychosocial hazard. I would request on notice some more information about your code. Is that something that is on the radar or being considered when formulating the psychosocial hazard code? If I look at it also in the context of potential sexual assault or trauma where there is proven risk, is that something that is being considered? Given that both perpetrators have the right to work and victims have the right to work et cetera, particularly in large government organisations and settings decisions could potentially be made without understanding unintended consequences or the risk to employees. Is that something that is at all on the radar?

Ms Deakes: Firstly, I would just say that the current legislation provides duties, and duty holders must ensure they are managing all the risks associated with both physical and psychological risks in the workplace. The scenario you are explaining would be that. We have recognised that we need to make our legislative framework stronger and more robust. As a result of that there are a number of things we are doing. In terms of psychological hazards, the code of practice—which you mentioned—absolutely does recognise violence. It does recognise harassment, sexual harassment and bullying. It encourages the workplace to take it very seriously in terms of how they manage the risk.

Our code is based around the hierarchy of controls. The hierarchy, which is embedded in our legislative framework and risk management approach, has a number of layers. With all different hazards we always encourage employees to try and reach the higher order controls: engineering, basically removing where they can, and if not, managing it at the higher level through design that can be involved—in the scenario you are talking about—redesign of work and how people are engaged in the workplace, the type of work they do, the demands, what occurs there. Training and PPE, the lower order controls, are still very important; however, the code will absolutely try to encourage that top level. The other thing it does is reinforces the need for openness and reporting to the regulator. If somebody is unfortunately fatally injured in the workplace, seriously injured or requires immediate treatment in hospital—this is an existing legislative requirement—they have a duty to notify the regulator. The regulator will look at any of those that come in and make a decision on what approach to take, including going out with inspectors to investigate that matter.

As well, at the national level there has been recognition through the Boland review that we need to have a look at current incident notification requirements and make sure it is not just event based: it is cumulative. On those definitions I just provided you around fatality, serious injury and immediate treatment, there is an opportunity here to recognise in the incident notification that I may be injured today but not diagnosed for some time. That process is currently going through the Safe Work Australia process and that will be considered by our government as well. They are the types of things we are trying to do in our regulatory system to really make it robust, but just having that alone

does not help. It has to also be followed up through our strong regulatory mandate with our inspectors. We need to make sure that we are getting out to those who are not as organised as the organisations that you are potentially talking about.

What does it mean for small business and how will they respond to these new regulatory environments? We are fortunate to have our industry safety standing committees. They are regulated under our legislation. They represent all the high-risk sectors. In that space we go to them, we consult on these things. We have steering committees that help us design these things. When we get to the point of implementation on the ground we go out and work with them about what it looks like for them. Yes, I suppose in response to that unfortunate scenario you provided they are the things we are trying to do, and have done already, in relation to our regulatory framework.

CHAIR: Do you need something taken on notice, member?

Ms CAMM: I would like you to, if you can, provide the psychosocial hazards code.

Dr MacMAHON: My question is for Mr James. Your submission mentions in particular the risks to people who are in insecure work. I wonder if you could just elaborate on the kind of environments where that is created and the outcomes. Ms Maxwell, is your organisation coming into contact with workers who are in insecure work?

Mr James: I might move to Ms Cox, who works in that space and is able to answer that question in terms of vicarious work and the risk to workers.

Ms Cox: In relation to the preventative side, for our own organisation it is really twofold: looking at vicarious trauma, a means to protect our own people; on the forefront of our programs, underpinning any of our advancement towards this code of practice or the like. First and foremost, it is looking at self-care. It is looking at the ability to provide support in vicarious trauma. That is certainly what we are focused on at present. I can provide further information if that is what is necessary.

Mr James: If I can just summarise as well. In terms of precarious employment, we know that high job demands, low job demands, basically lack of clarity about role responsibility and certainty—and I would suggest that in precarious employment it is this uncertainty about longer term employment, continuous employment and also the spinoffs with that in terms of accessing loans, accessing financial security. I would suggest that they are fundamental issues and I think that—and I mentioned earlier in my opening—they are drivers to cumulative mental health triggers or risks.

Mrs McMAHON: I just wanted to go back to the chair's opening question in relation to some of our IR frameworks. Given that the rate of mental health conditions, even those not work related, are quite prevalent in the community, what support arrangements do we have for workers who in their own personal lives experience mental health issues or concerns, and what are those leave arrangements or entitlements to allow people to deal with or address these issues and continue to be productive in the workplace?

Mr James: I can talk about the state's jurisdiction, which is the QES. There are provisions there for personal leave. Within the state's Public Service there are special leave arrangements available for various periods, and they are sometimes at the discretion of the chief executive. In the national scheme, whilst Queensland is a partner in the scheme it is run by the Fair Work Act, and that is the responsibility of the Commonwealth Government. The NES, the National Employment Standards, also have personal leave arrangements which can be accessed.

In terms of support for workers generally, workers can join their registered industrial organisation, their union, to seek support. They can also talk with their employer regarding support. I will be the first to admit that the community's expectation around dealing with mental illness has a long way to go, but there is a growing expectation and a growing awareness of the impacts of mental health in the workplace. We know from workplace health and safety and from the workers compensation scheme that there are legislative frameworks around, but in the workplace—at the site—it really is about a cultural change and an attitudinal change by employers and employees and society to drive better outcomes.

Mrs McMAHON: I am concerned about someone who potentially has a mental health issue but knows there is either no supportive leave arrangements or no extended periods of time off. Particularly with the stigma of mental health this means they may choose not to seek help or take the time off, which then has further snowball effects. What are the mechanisms when someone exceeds their sick leave or other leave entitlements?

Mr James: Certainly the scenario you predict is happening; I would not deny that. Employees should seek the support of their registered organisation if they require that sort of support. If they feel they are being dismissed or unfairly treated, there are adverse action provisions available in both the

Public Hearing—Inquiry into the opportunities to improve mental health outcomes for
Queenslanders

state and the Commonwealth legislation which prohibits an employer from acting adversely against an employee. However, equally, employers are bound to provide particular amounts of leave legislatively and beyond that it may turn to periods of unpaid leave, which I accept is a difficult position for the worker.

CHAIR: I would like to thank you all for the submissions and your evidence that you have provided here. It has been very useful for the committee. Thank you all for the work that you do around keeping workers safe. It is certainly something we all take to be incredibly important. It is certainly fundamental to those of us on this side of the House, and I am sure all share those views. We had two questions taken on notice. If we could have the response by the close of business on 26 April, that would be greatly appreciated. Thank you very much for your time today.

Mr MOLHOEK: It would be interesting if there is any other data around—I cannot remember the term—those project time frames to gauge progress.

CHAIR: If you can take that on notice, thank you.

CURTIS, Ms Mary-Anne, Associate Director-General, Housing and Homelessness Services, Department of Communities, Housing and Digital Economy

CUTHBERT, Ms Madonna, Acting Executive Director, Programs, Housing and Homelessness Services, Department of Communities, Housing and Digital Economy

KENYON, Ms Sharon, Acting General Manager, Service Delivery, Housing and Homelessness Services, Department of Communities, Housing and Digital Economy

VIOLET, Ms Irene, Deputy Director-General, Communities, Department of Communities, Housing and Digital Economy

CHAIR: I would like to welcome representatives from the Department of Communities, Housing and Digital Economy. Would you like to make a brief opening statement before we go to the committee for questions?

Ms Curtis: Firstly, I would like to acknowledge the traditional custodians of the land on which we meet today and pay my respects to elders past, present and emerging. I would also like to acknowledge anyone with lived experience of mental health challenges and their families and carers. As introduced, I am joined by my colleagues from the department today.

Access to safe, stable and affordable housing is a significant contributing factor to positive mental health and wellbeing and enabling social and economic participation in society. The Department of Communities, Housing and Digital Economy is working collaboratively with our sector partners and across government to support positive outcomes for people experiencing mental health challenges. Many of the people we assist have complex circumstances and engage with multiple human and health services and providers and require additional support to sustain successful tenancies. People with lived experience of mental health challenges have higher rates of unsuitable housing, greater housing instability and experiences of homelessness. They experience variability in housing pathways and reduced choice of living conditions and neighbourhood amenities. In addition, comorbid physical and mental health issues can undermine a person's ability to sustain tenancies as well as limit social and economic participation. There is a complex intersection between a person's timely access to mental health support and other human services and their housing stability and tenancy sustainment.

The Department of Communities, Housing and Digital Economy is committed to provide access to safe, secure and affordable accommodation for Queenslanders that meets their needs and enables social and economic participation. Through the Queensland Housing and Homelessness Action Plan 2021 to 2025 we are working to ensure those most in need are supported, and housing instability and homelessness are prevented. We are co-designing the homelessness and housing service system and practice improvements with service users and sector experts to create better service integration across government and community services through pathway planning and information sharing. We are delivering coordinated responses for people with complex support needs who are experiencing housing, mental health, alcohol and other challenges including specific place based responses in Cairns, Townsville and Mount Isa. We are also equipping government and sector workers to understand, identify and respond to the interdependency between mental health, homelessness and housing need.

We have also committed to developing a service delivery framework between state government agencies to prevent people exiting services into homelessness. This will include people exiting mental health inpatient and extended treatment services to ensure responsive person-centred housing solutions are developed with customers. We are committed to working with people with mental health challenges to access short- and long-term housing solutions, connect with supports, create opportunities and reduce barriers for tenancy sustainment. As well as connecting people to a wide range of housing supports, our housing service centre staff support people to connect with services including mental health; neighbourhood disputes; domestic, family and sexual violence services; boarding services; and linkage with the National Disability Insurance Scheme.

We also promote a range of programs to support tenant mental wellbeing including Your Mental Wellbeing, which is delivered by Queensland Health, and myCompass, delivered by Black Dog Institute. We are working with funded sector partners to embed holistic, person-centred responses including immediate supported accommodation. We will continue to work with experienced support providers such as St Vincent de Paul, the Salvation Army and Mission Australia on best practice models of support for this approach. Our aim is to limit the experience and impacts of homelessness

while transitioning people to appropriate housing and assisting them to connect to any additional required supports. I will now pass to my colleague Irene Violet, who will provide some opening remarks in relation to the communities portfolio.

Ms Violet: I will be very brief. Thank you for the opportunity to attend today. Communities has been supporting the work across government with respect to the social isolation and loneliness parliamentary inquiry that took place last year. That is a main area of focus for us in working with colleagues across the sector on supporting the government response to that. Many of the submissions that were heard by that committee and our work intersects with the terms of reference for this committee as well.

As I said, we have been working with government and non-government agencies, including those who deliver mental health and wellbeing services. We heard, most importantly, from individuals who have lived experience of social isolation and loneliness. As I said, those submissions help us consider our response to social isolation and loneliness such as the structural and societal functions as drivers and risks to mental health, the marginalisation of people living with mental health, the impacts of the COVID-19 pandemic as well as the mental health conditions experienced by First Nations peoples.

In consultation with other agencies, we are working on the 14 recommendations of that inquiry. In the communities division within the department we also fund a range of services that support people in the community living with mental illness. That is really designed around improving social connectedness. It is funding for things like neighbourhood and community centres, services such as the Queensland Community Support Scheme and also community transport and diversionary services.

The Queensland Community Support Scheme supports people under 65 years of age or Aboriginal and Torres Strait Islander people who are under 50 years of age with a disability, illness, mental health or other condition that has an ongoing impact on their activities of daily living. This scheme funds services that assist people to build confidence and access their community to participate in activities which enhance their social connectivity and help reduce social isolation. The services can also facilitate the re-establishment of relationships with families and friends that are sometimes lost as a result of a person's mental health challenges by providing supported interactions between clients and their families.

As I said, the department also invested over \$18.1 million in neighbourhood and community centres last financial year. We have also partnered with organisations on services that deliver emergency relief responses from those centres. It has found that in the case of people who typically attend neighbourhood and community centres mental health illness is one of the top five reasons they are seeking support. We are now working with the neighbourhood and community centre sector to work on ways that we can better work with that sector as a network and to look at foundational social infrastructure to support positive mental health for individual and collective wellbeing.

CHAIR: One of the first things I reread when I was appointed chair of this committee was that inquiry into social isolation and loneliness. That particular inquiry looked at those issues around people and levels of support in the community. I am assuming that when we talk about people who are homeless as a cohort, the levels of mental illness would be extremely high and potentially a contributing factor to that homelessness. A number of people giving evidence have talked about the need for better navigation and case management services that follow the person rather than be provided by a specific department and then withdraw those services when that person no longer has contact with that department. What would be your view in relation to something like that, which seems to correlate with some of the work in the social isolation report?

Ms Curtis: I will start with some comments and then pass to my colleague. As we flagged in the introduction, we do provide housing support to some of the most vulnerable people in Queensland, many of whom do have very complex circumstances and do require that additional support to sustain the successful tenancy. We know that access to safe, stable and affordable housing is a significant contributing factor to positive mental health and wellbeing and enabling social and economic participation.

Under the Queensland Housing and Homelessness Action Plan there are a number of actions to support the housing and homeless service system and deliver better outcomes for Queenslanders. As part of that we are working to develop a more formalised service delivery framework between state government agencies to help prevent people to the point that you had raised around exiting government services into homelessness. This will include people exiting mental health services to ensure that responsive person-centred housing solutions are developed with customers to support their mental health and wellbeing.

When we are working with people who might be seeking homelessness support we do have very much a pathway planning process we work through with them. That is looking at their needs and how we can better support their needs through a housing solution but making sure they remain connected with the services they have in place to support their particular needs.

Ms Kenyon: I would add to that that under the housing strategy through our first action plan we have had a strong focus on service transformation, which Mary-Anne has mentioned in terms of pathway planning. Traditionally, access to housing assistance in the past has been focused on eligibility. The pathway planning focus enables us to have much stronger and more holistic conversations, taking into account there are many factors that impact a person's ability to access, sustain and be connected to their housing outcomes. The focus for the first pieces of work has been strongly about making sure we are integrated with service providers and partners on the ground around our housing service centres so that we are understanding and having deeper conversations with people and their supports to understand what their needs are and then are able to collaboratively respond to those. The concept of pathway planning is to meet the person where they are and support them on a pathway.

For some people that will be about a very beginning connection around supporting their health outcomes to enable them to go into a tenancy and start to meet the requirements of a person who has a rental tenancy. For others it will be about connecting them to ongoing other supports. I use budgeting assistance as one of those examples. The concept of pathway planning is to understand the person's needs and to be able to put around them the support services and integrate around them to enable them to have successful housing outcomes.

In terms of some of the work that has occurred in the department, in 2020 we stood up a specialist response team that enables a multiagency response to support very high-need clients in terms of those very complex scenarios where they currently require support from a number of human service agencies or non-government providers. We are working with those on a person-by-person basis so it is very connected in with the health and hospital networks, where that is the case. We have also implemented some case coordination approaches across Queensland in the regions. I might offer Madonna an opportunity to talk in detail about those.

Ms Cuthbert: Before I move onto that, I go to the point about identifying the need for support to follow a person through the system. I draw on the example of the work we have been doing in the inner Brisbane response where we are working very closely with St Vincent de Paul, the Salvation Army and Mission Australia at the two inner Brisbane hotels that we have stood up. We have established a specialist homelessness operational practice team with those services to really work through a best practice model in that context. While it focuses on short-term stays with really comprehensive needs assessment, 24/7 on-site support and case management with multiagency service responses, it also brings in the pathway planning for individuals. Where needed and possible, it provides the support to follow the person via an enhanced mobile support service. The work we have done there is actually really quite pivotal to what we do into the future.

Under the action plan, under action 6.1 I think, we are committed to doing a co-design of the homelessness and housing system as a whole. The learnings we have from those sorts of responses that we have been able to stand up pretty quickly during COVID and continue—and that is just one example—really will come to that piece of work to see how we can actually pivot some of the range of service types we provide under the homelessness program to provide that continuing support.

Going to the point that Sharon raised about the coordination of service delivery that we have stood up, there is what we call a coordinated housing and homelessness response initiative where we have established coordinators in a number of centres to really work across housing and homelessness services and also other mainstream services in those locations to coordinate the response for individuals. In this year's budget, the government committed to ongoing funding for that service and also some funding to expand it into identified priority areas, which we are currently doing. That work is really starting to show some good outcomes at the service delivery level. It works a little differently in places, which is a good thing, because we do really focus on a place-based response.

CHAIR: The federal Productivity Commission talked about the need to push planning down to the lowest level at a regional level. They anticipated HHS and PHN involvement. Would you see a role for Communities and Housing to be involved in planning mental health services and responses on a regional level?

Ms Curtis: I think that is a key part of that place-based model and planning. I think it is around how we work in that multidisciplinary way, in that person-centred approach that we have talked about, to make sure that the services that are needed are available to support the need that might exist. How we work with our service providers and other government agencies across the sector is really important as part of that place-based response.

Mr MOLHOEK: Could you comment on any models of housing that are excellent or good examples of supportive housing for people with mental health issues? How are we managing those special needs within our public housing and other housing systems? I declare that I do have an interest around Common Ground. I am interested to know what other supportive housing models there are and how we look after people with mental health issues in the public housing system.

Ms Kenyon: I am happy to start with respect to the public housing system and broader service delivery. In terms of having contact with people who have housing assistance requirements, we work with people through our housing service centres. We have talked about pathway planning and making sure that at the point of connection we are connecting them with services or referring them to other support services where required.

In terms of when we are the tenancy manager in these cases, we take a supportive tenancy management approach and have a range of operational approaches in terms of managing tenancies. There are policies that relate to expectations around behaviour and requirements that fit, from our perspective as landlords under the residential tenancies legislation and supporting people who do require additional assistance. As we have reflected in the opening statement, often we are providing tenancies to people who are the most vulnerable with the most complex of circumstances. Really, it is working with people to connect them to support but also to understand the causes of behaviours that can be contributing to complaints or concerns from neighbours and taking, I guess, our responsibility in terms of balancing those needs and the needs of the neighbourhood when we are working with our tenants. In terms of those activities, it will be about, again in the same way, working with the person to understand what is causing the circumstances, seeking their support to work with other agencies where there are specific requirements and then assisting them through. Obviously through the tenancies legislation there are opportunities and provisions that enable us to support people and provide warnings and enable them to understand what is required in terms of the tenant then managing their tenancies.

Mr MOLHOEK: What you are actually talking about is how we manage difficult—

Ms Kenyon: Public housing tenants, yes.

Mr MOLHOEK: I am more interested to know what supportive housing we have available and provide. We have heard testimony from previous respondents, both to this inquiry and to the Health and Environment Committee's inquiry, around the important role that supportive housing plays and the shortage of good supportive housing. I think it was the nurses' union that talked about how effective supportive housing saves millions of dollars in police time and ED diversions. I am keen to know what plans, ideas or programs Queensland Housing has to increase the supportive housing stock. What collaboration do you have or would you like to see more of so that we can better look after people in public housing or affordable housing with mental health support?

Ms Cuthbert: We do have a range of supportive housing models. Common Ground is the example where we have full-on 24/7 support on site. It is a very specific model. There are other examples in various locations around the state where we do have support providers on site. It is not quite the same model as Common Ground. I would be happy to provide some more detailed information about those models.

Mr MOLHOEK: That would be great. Could we have perhaps a note or a paper on all the other models that Queensland Housing supports?

Ms Cuthbert: The other example that I would draw to your attention today would be the work we have done with young people with the youth foyers, which is a form of supportive accommodation or housing, albeit there is a commitment from the young people to be involved in earning and learning, and other programs are provided on site. We have an example of a development in inner Brisbane for young people with support provided on site. That is a fairly recent development, in the last couple of years.

CHAIR: Where is that?

Ms Cuthbert: It is in Woolloongabba. There are a range of examples across the state with both adults and young people. The other one that I would bring to your attention is a trial, which you have now continued to fund, that we did for families, again with Micah and Common Ground. It is supportive housing for families. That has been a disperse model, so a headlease model, where they can provide support to those families in the community. That will continue but we are also looking at single-site models for families, providing that on-site supported model similar to what we do with Common Ground, but with a families focus. That is some new work that we are doing. In the work we are doing around the co-design piece of work, there are a range of models that we need to consider in place, Brisbane

so what is appropriate in particular places. We are not advocating the same model necessarily for every place but taking the learnings from all of those different models and looking at what will work in a particular place.

Mr MOLHOEK: Director, in the National Mental Health Commission's strategy Shifting minds they say that the No. 1 priority should be housing, so stabilising people, and then I think there are four other priorities after that. Would you agree with Ivan's commentary on that and the findings or views of that strategic document?

Ms Cuthbert: I think, just picking up on that, there were four pillars. One was access to affordable housing, access to good health care, psychological care and employment and training. Access to housing is a critical factor. I think we also need to consider that housing alone, without support and without an integrated support model to support people, whether it be in a single site or in the community where the majority of people will be, may not work. I would say that you are looking at both components.

Ms KING: Thank you all for being here and thank you for the work that you do every day in housing and community and other spaces to assist Queenslanders to manage and improve their mental wellbeing. My question is most probably directed to Ms Violet, but if anybody has anything further to throw in, please do. I want to ask about the role of neighbourhood and community centres specifically in working with Queenslanders who may be in mental distress or suffering from socioeconomic factors that threaten their mental health. Can you speak to us about some of the programs delivered via neighbourhood and community centres? I want to particularly acknowledge my own local neighbourhood centre which does an incredible job, the Bribie Island Neighbourhood Centre. I know they play a huge role in the mental wellbeing of my community. Maybe you could speak more broadly about some of the supports provided through that network.

Ms Violet: You are right: neighbourhood and community centres play a really vital role in community connection and wellbeing. Through the government we fund 127 neighbourhood and community centres across the state, and they provide a range of programs depending on the needs of their community. What binds them in terms of their commonality is being a soft entry into the system and service navigation, which I think was part of one of the earlier questions. We heard that particularly through the COVID experience. Through the strategic repositioning work we are doing at the moment, we have heard that our neighbourhood and community centres have had people visit them who have not needed to engage with the system previously because of the impact that COVID has had. That continues to be a present factor in the referrals neighbourhood and community centres receive.

There are a number of things they do which are just bread and butter in terms of that service navigation, trying to get people connected to the services that they need. A number of neighbourhood and community centres also deliver emergency relief services, and that is something where we have experienced an increase during the COVID pandemic. The types of programs tend to be responsive to the needs of the community. One of the things I would like to call out is that in some places we fund Community Connect workers. That is really about service navigation, trying to connect people with their communities.

We have recently engaged with neighbourhood and community centres in some particular areas for Care Army, Connect volunteer workers. We know that volunteering is a really strong part of getting people connected to their communities. That is part of one of the election commitments that was made to ensure we continue that legacy of the Care Army's work. Another one of the initiatives we have recently taken forward is financial resilience workers. That has been a really key part of people successfully coming out of the COVID pandemic. It really connects to some of the things that my colleagues from housing were talking about. Those sorts of things are responding to the needs we are seeing now but, as I said, they really respond to the general needs of their community. Obviously with the South-East Queensland rainfall and flooding event we have all experienced or are still recovering from we have been able to connect with neighbourhood and community centres in those locations. That has been really valuable for us. We have been able to stand up some on-the-ground responses, working with our colleagues in the Salvation Army and lifeline.

We are now doing some planning around those neighbourhood and community centres being an ongoing resource for the recovery of those communities. We saw that work really quite well after the 2019 monsoon event in Townsville. It really helps. I guess we have covered the breadth of things happening in neighbourhood and community centres.

Ms KING: One of the key themes in the submissions we have received and the in-person evidence we have heard through this inquiry is about what is commonly termed the missing middle of mental health services. I wanted to ask whether you think there is capacity for community and
Brisbane

neighbourhood centres in particular to be part of a response to provide a missing middle through whatever pathways, programs or approaches were decided upon. Do community and neighbourhood centres have that capacity? Are they well-placed to be part of that response?

Ms Violet: I would think so. That is certainly something that was looked at as part of the social isolation and loneliness inquiry. It is something we are looking at. What is the ongoing role for neighbourhood and community centres not just in that service navigation but how do we make sure that we have a platform that connects with community wellbeing, social connection. It is sort of those protective and preventative factors. We see that neighbourhood and community centres, given the nature of the infrastructure we have across the state, are really well-placed to play a pivotal role in that community wellbeing—obviously not at that acute end for mental health, but certainly in developing more those sort of protective, preventative factors. There are a number of things we are looking at as part of the response to the social isolation and loneliness inquiry that will help address some of that missing middle, but it is something that we would certainly be looking at as part of our ongoing strategy.

Ms CAMM: I really appreciate your recognition of people now coming into services who have never come into services before. My question is around the neighbourhood centres but more broadly also around recognition that there is a significant shortage or crisis in the space of affordable and accessible housing. With your review and the 127 centres the government is funding to \$18.1 million, are you able to provide a breakdown per region? The reason I ask that question is because my interest in this committee work is very much about regional rural demand, need and inequity. I have amazing neighbourhood centres in my community, as we do across the entire state, but I am just interested to understand the breakdown of funding per region. I am happy for you to take that on notice. Subsequent to that, is it something the department is considering when you are working potentially across departments or collaboratively where you see growth in demand?

I will give you a live example. I was on the Gold Coast last week visiting the St John's Crisis Centre in Surfers Paradise. They are not currently receiving any government funding at a state level. They receive some financial funding to provide food in a crisis setting, but they are permanently funded philanthropically, which is fantastic. There is such a generous community there. They are also seeing—and is this something you are seeing through neighbourhood centres that are funded by government—women with children living in cars and now even professional people who require support because of the flow-on impacts of rental shortages et cetera. Can you just speak to that? Is that a trend you are seeing grow? Because obviously that is contributing significantly to people's mental health and wellbeing.

Ms Violet: In relation to the first part of your question in terms of the regional breakdown of funding, if I can take that on notice and supply that to you separately that would be good.

The information we get through Neighbourhood Centres Queensland—it is the peak organisation—is that they are certainly seeing increased visitation, as I said, to all neighbourhood and community centres. I guess it is for a broad range of support and services which includes, as I said, that emergency relief work and other supports in terms of accessing other services. In terms of that specific case example down at Surfers Paradise, I am not familiar with that, obviously, but I can speak generally. Through Neighbourhood Centres Queensland we are seeing reports of increased general demand in terms of support and assistance right across the spectrum from income support through to other needs.

Dr MacMAHON: For those people who are on the social housing register, does the department have data on how many of those people are living with mental illness? Where does mental illness fit into the wellbeing criteria that people need to meet in order to be eligible for housing?

Ms Kenyon: We have data in terms of each customer's circumstances, including elements such as: service providers they are working with, any particular requirements they might have in being supported to manage tenancies, any particular requirements they might have around where they need to live or where they prefer to live because of connections to services et cetera. In terms of our tenancies, we would be aware when we have engaged with people around particular issues that might have arisen. We do not have a dataset that accommodates a drawn up dataset around that that is kept at the individual customer level.

In terms of wellbeing criteria, the range of wellbeing factors that are considered are all focused around people's ability and capacity to access accommodation and then to sustain it where there are issues or circumstances that might limit people's ability to access accommodation. An example I might draw on is when people are not able to navigate the private housing system, not able to present to real estate agents or provide documentation that might be required for assessment, they are

certainly supported in terms of that focus. Those are factors that would be taken into consideration. In terms of their ability to access and sustain, particularly where people require health or other services in order to meet their daily living requirements, those factors are taken into consideration. The wellbeing focus is around what are the factors that need to be supported in order for someone to have a positive and sustained housing outcome. That is the key part to that.

Dr MacMAHON: Do you have any data on the tenancy programs that were mentioned, Your Mental Wellbeing and myCompass, and how successful they have been in supporting people to have secure tenancies?

Ms Kenyon: Those two programs are programs delivered by other organisations which we have flagged as being particularly available to people. We do not have data in terms of the tenants who may have been referred, but that is the level of engagement that occurs. I think, in relation to Irene's commentary earlier around neighbourhood centres, these are services that at a local level people are often referred to and are engaged in in the processes around the integration of service delivery. In our place-based approach, local housing service centres as well as their government and non-government partners are aware and invest in understanding the services and how to support people to have whatever is the best connection and referral. I do not have specific data around those two.

Dr ROWAN: With respect to Queensland's Housing and Homelessness Action Plan 2021-25—and I know we sort of touched on a lot of the commentary so far—that integrated health and housing response to vulnerable Queenslanders, specifically people with mental health conditions, with respect to those pilots in Cairns, Mount Isa and Townsville—I know it is early days—is there any sort of evaluation or results to date as to how that is progressing so far?

Ms Kenyon: Yes, it is early days. One of the things to reflect on is the COVID response across the state, particularly having had lockdowns for periods of time in Brisbane, Cairns and Townsville. We have worked very closely with the homelessness sector through those processes which has enabled us to do some very early work in terms of understanding in a time of disaster or crisis or health response what the issues are that each of those places is seeing and to build those relationships around developing new models. I would like for that not to be underestimated because a significant amount of work happened very quickly in terms of unpacking the system on a daily basis—having what we refer to as stand-ups, which is coming together at the beginning of each day and engaging with all service systems, even wider than Health and Housing in those circumstances. The process we used then to undertake a review about how those things have worked has set the foundation for our work going forward.

The recent weather events in the south-east have also offered us that same opportunity to understand from people who are experiencing it and the organisation involved to see where those connecting points could be enhanced or developed further. As my colleague Madonna talked through models that exist, we tested some of those in action in those circumstances.

Dr ROWAN: I have a final question that may have to be taken on notice. In relation to homelessness in Queensland, is there any data that the department is keeping with respect to alcohol and other drugs causing homelessness or occurring as a result of homelessness?

Ms Cuthbert: I would have to take that on notice. The AIHW collects where a person has identified as having a mental illness. In 2021 it was about 28 per cent, but it does rely on people identifying themselves. I would have to come back to you on whether we collect data on drug and alcohol issues.

Dr ROWAN: That would be great. If you could take it on notice and provide us with any information that would be helpful for the committee.

CHAIR: I thank you for your submission and for taking the time to appear today. Thank you to all of you for the work you do and the work of your departments. For those questions that were taken on notice, we would like the responses by the close of business on 26 April.

Proceedings suspended from 11.17 am to 11.34 am.

**AINLEY, Mr Elliott, Industry Liaison Officer, Australian Counselling Association (via
videoconference)**

CHAIR: Good morning. We will resume the public hearing for the committee's inquiry into the opportunities to improve mental health outcomes for Queenslanders. I welcome Mr Elliott Ainley from the Australian Counselling Association. Elliott, if you would like to give us a brief opening statement we will then go to questions from the committee.

Mr Ainley: Thank you to the committee for the invitation to appear at this hearing today. I would like to acknowledge the traditional custodians of the lands on which we are gathered today and extend this respect to the traditional custodians of the lands where others might be joining from today and pay my respect to elders past, present and emerging.

I am representing the Australian Counselling Association—the peak body based here in Queensland with approximately 10,000 members. Firstly, I will give a quick recap around registered counsellors. The average profile of an ACA registered counsellor is somebody between the ages of 40 and 60, who is usually on a second or third career change. Some 75 per cent of our members are female. A large proportion of our members have grown families or teenage children. The average member will be somebody who will most likely already hold a formal qualification from a past career. A significant number of our members are past teachers, social workers, medical doctors and nurses. Many members come from professions such as the police service, the military, ministries, belief systems and stay-at-home mums whose children have left and they have chosen to come back into the workforce.

Many people ask what the difference is between a counsellor, a psychologist, a psychiatrist and a social worker. Most people will answer based on a qualification and registration process, as you have no doubt heard. I think people miss the more important difference. The significant difference from our perspective is the qualities that counsellors bring into mental health that others do not—age being one factor. The average counsellor when they graduate is 40 to 45 years old in comparison to the average psychologist and social worker who is approximately 26 and psychiatrists who are around the 28 mark, give or take a year.

Another significant difference is the disciplines. Counselling is the only one where the average new graduate already has a significant work and life experience prior to their graduation. They can speak from a perspective that most new graduates in other professions cannot. They are able to get this from the get-go. They legitimately understand life's challenges beyond being a youth and studying. They can draw on real-life experiences and not just theory.

Having 20 or more years of life experience before coming into a profession also ensures that counsellors are resilient. Due to their life experience, counsellors are reticent about making a diagnosis and prefer to simply work with the human being that sits in front of them, listening to their story—which in many cases is a complex one with many layers—before then determining if a diagnosis is necessary or, in fact, in the client's interest. This should not be misinterpreted to mean that counsellors are not qualified nor trained to make the diagnosis. A common myth held within mental health is that counsellors are not able to do that where many actually are.

Each member of the ACA has been able to verify, through formal documentation, that they meet ACA's training standards. They undertake regular clinical supervision, undertake regular professional development and adhere to a stringent code of practice which incorporates our complaints mechanism. Our members have also had to adhere to legislative requirements, depending on the nature of their position. ACA requirements are rigorous. Once a member meets those requirements, they are placed on the ARCAP register, which is a joint register between ACA and PACFA—the Australian Register of Counsellors and Psychotherapists. To give you some perspective as to the ACA's growth, right now we are averaging around 100 new members per month and there are an estimated 7,000 students currently studying either a bachelor or masters program in counselling, all which are ACA accredited, Commonwealth supported and designated as a professional pathway into counselling by the Department of Education.

I have heard over the course of these hearings from the APS in particular. I would like to quote directly from the APS senior policy adviser, who stated—

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.

Public Hearing—Inquiry into the opportunities to improve mental health outcomes for
Queenslanders

There are approximately 2,200 ACA registered counsellors based in Queensland—30 per cent in regional and rural areas. All are trained, insured, ethical, accountable and ready to go now. Our members are already in the private school system in Queensland and we are recommending that the Queensland government introduce registered counsellors into the public system as well. The ACA recommends access to registered counsellors in hospitals where burnout is currently a major issue. Registered counsellors are better placed than psychologists and social workers in this space to provide the type of frontline counselling required, with no diagnosis, early intervention, with potentially ongoing referrals—so triage counselling if you wish.

WorkCover Queensland has already identified counsellors as a cost saving measure. We encourage the state government to make a recommendation to the federal government to bring counsellors into the MBS. We also recommend the Queensland government utilise the full spectrum of available practitioners to address the workforce issues and to make service provision more widespread. We also recommend the Queensland government update their definition of allied health practitioner in Queensland to include registered counsellors.

The APS has identified that they want to bring their interns in to do this job—and by this I mean professional psychologists. That is not a viable solution. To supervise these professionals you have to take psychologists away from the front line. This is based on Ahpra's own guidelines. So registered counsellors are here, now, ready to go—standards are national, accreditation, competency, supervision, accountability, years of experience and also the evidence shows equal outcomes when compared to psychologists and social workers.

I thank you for allowing the ACA to be present at the hearing. I welcome any questions from the committee.

CHAIR: I have a couple of clarifying questions. The registration that you have is self-registration and you are not Ahpra registered?

Mr Ainley: No, we do not come under Ahpra. One of the main implications of being registered by Ahpra is that you have to be a threat to the public in a sense to be regulated. There is very little evidence for that that we have seen. There was recently a paper done by Converge International looking at counselling, psychology and social work in an EAP setting. It showed that counsellors get significantly fewer complaints through the complaints mechanism. For us to fall into that Ahpra regulation we have to show that we are damaging and we are essentially not. We have been told by the federal government through our advocacy work that, as a self-regulated industry, the procedures and policies we have in place are sufficient already in that regard.

CHAIR: You would still be captured by the OHO in Queensland if you were putting a shingle up that says you are a health professional. Regardless of whether you are registered or not you are still captured by that system. You are not able to access the Medicare Benefits Schedule or refunds of any description?

Mr Ainley: No, we have everything but that from WorkCover to private health to EAP to victim services in other states such as New South Wales. Medicare has been a bugbear for us. It is something we are still working on with the federal government. The thing in our regard needs reforming because it is all based on a medical pathology model.

CHAIR: A lot of submitters have talked about the fact that, particularly in light of the NDIS, a lot of services have been driven towards one-on-one type services whereas there is a real need for psychosocial responses as well as group responses. Are counsellors placed to operate in both the one-on-one space and the psychosocial group orientated approach?

Mr Ainley: Absolutely. We already have members working in multidisciplinary teams in all areas, including NDIS and private practice, providing services from early intervention up to moderate intervention as a further step care model and in some cases high levels of intervention.

CHAIR: Can you clarify for me that counsellors are not currently employed by Queensland Health or Queensland Education?

Mr Ainley: No, not to my knowledge.

Mr MOLHOEK: In your submission you talk about the fact that many counsellors have at least two years of full-time practice. I am just wondering if you can tell us a little about how one becomes a counsellor and how much study is involved? As I understand it, there is the opportunity to become a counsellor through perhaps doing something like a social services degree. You can super specialise. There are other pathways. There are weekend training courses and there are short courses and certificates.

My question really is: how does someone become qualified and how would we decide which counsellors have sufficient experience to perhaps even be eligible if Medicare were to look at changing the system? How would we even determine that someone has sufficient life experience and real experience so that we could trust them to be a counsellor in an ED department, or any other setting for that matter?

Mr Ainley: That is a great question, Rob, and something that we get asked often, being an unregulated industry. I will remind the committee, as well, that there are actually more unregulated allied health industries than there are regulated ones, including the social workers.

Legally anybody can call themselves a counsellor, but for the context of an ACA registered counsellor and for the context of this hearing we refer to our level 3 and 4 members that, as you pointed out, clearly have two years. They all have a minimum of a bachelor's or a master's degree in counselling, which is accredited by the Australian Counselling Association. They have 1,000 hours of client contact and also 100 hours of clinical supervision for our level 4 members and 75 hours of supervision for our level 3 members. We are not talking about counsellors who are fresh out of university; we are talking about counsellors who have been delivering these services for a couple of years.

We use our level system to differentiate between those members in the way that the psychologists use provisional/general/clinical to differentiate between their own members. Whenever we do advocacy work, whether it is for WorkCover, EAP, private health or NDIS, we always refer to our level structure. That would be no different in the suggestions we are making to the committee and to the Queensland government. We have a submission to the federal government for Medicare for us to come in line with the psychologists and the social workers. That is based on an ACA level 3 or 4 member. Again, that is a member who has completed a bachelor's or a master's in counselling with two years post-qualification experience, client contact and supervision.

Many members I meet who have done the Master of Counselling have actually come from a psychology pathway. As I mentioned to you before, there are around 7,000 students studying so in two years time we are potentially going to have another 7,000 level 3 and 4 members all meeting that Medicare criteria, as per our submission. A lot of those have come from psychology and social work streams. Because of the nature of an undergraduate degree in psychology, they do not actually give you any mandatory face-to-face client contact or supervision as part of that degree. I would know because I am actually doing one at the moment. In counselling, we have a mandatory expectation of our accredited programs that there is embedded supervision and placement as part of that to pass as an ACA accredited course. If you were to do a cross comparison of a three-year psychology student and a three-year counselling student at the bachelor's level, the counselling student would come out of university already having those interpersonal skills, client contact and exposure to clinical supervision whereas the psychology student would not.

Mr MOLHOEK: It sounds like the education system needs an overhaul or that there needs to be some changes to the graduate program so that qualified psychologists are required to do more face-to-face work prior to graduating.

Mr Ainley: I cannot really speak to the psychology side of things. With the nature of the industry and our work as a people-centred industry, counselling is an extremely rich and diverse industry and people come into this because they want to work directly with the individual. They do not want to work with an antiquated system developed in the states or the UK, based on the medical pathology model. They want to be working with people's history, they want to be working with individuals face to face, and dealing with those stories and those challenges. Those are the sorts of differences in a sense.

In terms of psychology, they then go on to their master's and have two years. My partner is a psychologist and she is currently a provisional psychologist. I promise you, it is a harrowing experience for a provisional psychologist so for me to hear that they want to bring provisionals into the system as essentially new graduates with no experience when we have thousands and thousands of members who have been doing this for, in some cases, a decade or two decades, it just makes absolutely no sense to me whatsoever. We have a workforce here to address the situation; we just need to bring it in and utilise it.

Mr MOLHOEK: If I was to come for counselling, essentially what is the difference between me seeing a psychologist and an experienced counsellor? Is the methodology or approach different? Do they look at things through a very different lens? What is the difference between a counsellor and a psychologist in a counselling setting?

Mr Ainley: When you look at it in the actual therapeutic setting, it depends whether or not you go through the MBS. The MBS mandate is based on the old Westminster system of CBT or cognitive behaviour therapy. When you go to a GP, the GP is financially incentivised to give the referral to a
Brisbane

psychologist, as I am sure you are all aware. GPs can refer to counsellors but they do not for obvious reasons. When you go through that system, that psychologist is mandated by Ahpra and MBS not only to do all the reporting but also to stick to certain therapies whereas a counsellor may use different therapies.

We do still learn the same psychological interventions as the psychologists. If you were to look at a psychology degree and a counselling degree, nine out of 10 times we have a minimum expectation in our programs of six different modalities and probably 90 per cent of those are covered in the psychology degree so there is absolutely no difference there. The difference is when you bring that medical model into play. A lot of psychologists, including my partner and people I know, deliberately do not use the MBS because they do not want to have to use that CBT diagnostic framework for dealing with their clients because there is so much evidence for different interventions and modalities out there now that it is like using blinkers, if that makes sense, so it has its own challenges. Going to your point, if you were to see a psychologist and a counsellor outside of the Medicare system, a lot of them are working in multidisciplinary teams anyway so you probably would not notice too much difference.

Mrs McMAHON: Elliott, I want to have a quick chat to you about the undergraduate workforce, notwithstanding obviously the thousands of registered counsellors who are ready, willing and able to assist in the mental health space. I declare that I am one of the thousands of Queenslanders with an undergraduate psychology degree who has never worked in the mental health space. Is there a bridging qualification or what would be required to activate those potentially thousands of undergraduates with qualifications, to get them ready and up to speed to work in the current mental health space? What would that require as you see it from a professional capacity but also from our educational institutions?

Mr Ainley: You are referring to my comment around the 7,000 who are currently engaging in the bachelor's and master's programs; is that correct?

Mrs McMAHON: No, I am talking about those who have completed psychology degrees. Obviously you have a counselling workforce that is ready and willing, but we were talking before about the many thousands who have completed study but do not work or meet any qualifications because of the hurdles through the psychology workforce. For those who do have undergraduate degrees with some kind of psychology qualifications but who are not currently registered, what could we be doing to get them up to speed?

Mr Ainley: They could be doing a Master of Counselling. That would be their quickest pathway into the workforce because that would ensure that they are coming out at the tertiary level. We do not accept an undergraduate degree in psychology as a membership of the ACA because it does not have that client contact, supervision and placement. There is an expectation that once you complete an undergraduate degree in counselling and psychotherapy you are essentially skilled enough to enter the workforce to some degree, whether it is getting experience, whether it is working for an organisation, whether it is doing further placement and that sort of thing. Psychology does not prepare you for that because it is largely research and paperwork, as I am sure you are aware as a graduate of one of those programs.

A Master of Counselling would be a two-year pathway to be able to register as an ACA registered counsellor. It would meet the requirement for access to Medicare rebates, were we to be successful, and meet all the requirements for the private health funds, for WorkCover in Queensland et cetera, which has a minimum expectation of a bachelor's or a master's degree as well. Many students I meet upon my travels have already adopted that. They have gone into counselling. To go through psychology it would be another two years of study, and then another two years as a provisional psychologist on top of that, before you are ready to properly enter the workforce.

Anecdotally, my partner is experiencing this at the moment. She has had maybe four or five supervisors drop her in the past couple of weeks alone because they just do not have the time, there are not enough of them and they have primary and secondary supervision. A suggestion from the APS to activate the psychologists as they are now is, quite frankly, ludicrous because there is not enough people to be able to push them through. If they were to do a Masters of Counselling they would be ready to go because, again, our degrees already contain that exposure to the industry as a mandatory requirement.

Mrs McMAHON: Elliott, you are talking about the Master of Counselling. Currently in Queensland, within our various tertiary systems, say, as of next semester, next term or next year, how many positions are there in the Master of Counselling?

Mr Ainley: That is something I would be able to provide to you on notice. Off the top of my head I know that the Queensland University of Technology caps theirs at around 40 or 50 students per year. However, UQ also provide one, as do the University of the Sunshine Coast and the University of Southern Queensland and I believe Bond University too. I believe some of those are actually uncapped. It is a blended delivery so it is online and face to face. We can deliver programs online but there is an expectation that the placement is face to face.

The issue for the universities is not the number of students they can bring onto the program. I do not think anybody has any challenges with that. We have actually done a few surveys over the past couple of years of our bachelor's and master's accredited programs and they are all showing significant growth in that space. The challenge for the universities is the placements, because organisations are under the pump, they do not have the resources, they do not have the supervisors. Again, the challenge in the industry is with the placement issue as opposed to the actual universities being able to have capacity for those students, if that makes sense. That is something we are working with them on.

Mrs McMAHON: Just to finish up, if we were to crack the nut that is the role of counsellors within the Queensland mental health workforce and, therefore, we have more students engaged in this study—regardless of whether it is social work, psychology or counselling—then supervision, quality face-to-face time and feedback are the issues. In what government settings do you see students under supervision getting really good exposure or where can government departments be facilitating supervision in your opinion?

Mr Ainley: Pretty much in most areas, I would say. Again we have a high emphasis on supervision and our requirements for our own supervisors are perhaps slightly higher than psychologists and social workers in the fact that everything still has to be face to face; we do not allow anything online. We could look at the education sector. We could look at the hospitals and the schools, and whether there are crisis hotlines and areas like that. We do a lot of work with already established entities such as Lifeline and headspace and that sort of stuff. There really is no limit to where our members and students can be working because, again, we are all trained at the same level as the social workers and the psychologists. Across the board I think there is opportunity for all the disciplines to come into those spaces.

Dr MacMAHON: I note in your submission you highlighted the very high rates of psychological issues that GPs are facing. I think it is about 60 per cent of presentations. You have also noted the workforce issues around GPs and a progressive undersupply in the years up to 2030. What do you think counsellors could do to amend this and what can be done at a state government level?

Mr Ainley: Counsellors can be an immediate relief due to the way the Medicare model works. From a Queensland government perspective it is about informing the public around the choice and the decision because not many average Australians would know. As a peak body who is not for profit, we only have limited resources in this space for an awareness campaign around informed choice for the consumer. At the end of the day most Australians who go to the GP with these issues do not know they have them. The GP will use the K10 form—the psychological form they use to assess depression and anxiety—and then they will just say, 'Okay, sounds like you need to go see a psychologist. Here is a referral.' Obviously then leading into the psychology practices, as we have heard from the APS, there is three, six, eight, nine or 10 months spent waiting.

It is about enabling the GPs so that people can make an informed decision to see a counsellor. Most of our members are actually charging the gap fee to be competitive against psychologists, which is not an ideal outcome. The average fee to see a counsellor in Queensland is probably between \$90 and \$120, which is the expected out-of-pocket fee you would pay if you were to go to a psychologist after you had claimed the Medicare rebate. Obviously the benefit of seeing a counsellor is there is no diagnosis involved. It is a different area. The clinician is able to tailor the outcome to the individual as opposed to being mandated to CBT and to certain areas of the act, which is obviously predesigned through the Medicare system.

From a Queensland government perspective, it is about awareness, working with the ACA, working with the GPs, making those informed choices and helping the public to make informed choices as well.

Dr ROWAN: Thank you, Mr Ainley, for your presentation and submission. With respect to counsellors and other state jurisdictions are there any examples of them being included in their industrial awards framework? Are they captured in a standalone one or within another award structure you are aware of? The reason I ask that is if Queensland were to look at that with respect to additional employment opportunities and clinical service provision, whether it is alcohol and other drug services or mental health services, what would that look like?

Public Hearing—Inquiry into the opportunities to improve mental health outcomes for
Queenslanders

Mr Ainley: Sadly, we are included on a nationwide level. We do not have an award essentially for our own services. We would like to introduce a set award for counselling, because it is incredibly subjective at the moment. Again, most of our members are charging in that area to combat the—in terms of the difference between psychology and counselling, in essence, there is a saying in counselling that you do not become a counsellor to drive a Ferrari. I think the nature and essence of who we are as practitioners reflects that in the sense that we are prepared to work on a sliding scale to meet the service needs. If we have Queenslanders in regional and rural Australia or in lower socio-economic areas who can only afford so much, our members work to that. However, having an industry defined scale would be ideal for us, but unfortunately I think we fall into the services award at the moment.

CHAIR: Thank you very much for your presentation today and the submission you have made. I am sure other members have had contact with your association. I know you have been very active in reaching out to committee members and I thank you for that. The evidence today will be very useful in terms of forming our report going forward. Just to clarify, did you take a question on notice around university numbers?

Mr Ainley: Yes.

CHAIR: If we could have the response to that by 26 April that would be fantastic. Thank you very much.

KRULIN, Ms Vanessa, Solicitor, Senior Policy and Research Advisor, Aged and Disability Advocacy Australia

ROWE, Mr Geoff, Chief Executive Officer, Aged and Disability Advocacy Australia

CHAIR: Good afternoon. I would like to welcome representatives from Aged and Disability Advocacy Australia. Could I ask you to make a brief opening statement and then we will go to the committee for questions?

Mr Rowe: Firstly, I acknowledge the traditional owners of the land on which we meet and pay my respects to elders past, present and emerging. Thank you to the committee for the opportunity to, on top of our submission, present to you this afternoon. I will take our submission as read but make some opening comments.

ADA's interest—I will use ADA rather than Aged and Disability Advocacy Australia—is as an advocacy organisation, as a provider of community legal services who also does some work for the Mental Health Review Tribunal and also as a host for the Aboriginal and Torres Strait Islander Disability Network of Queensland and their new Indigenous advocacy service, which is a first in Australia, Side by Side.

We are really pleased that the government has seen the importance of mental health outcomes for all Queenslanders. While I cannot speak for all Queenslanders, I can certainly speak for the people we support. As a number of you know, we are a statewide organisation delivering services from the Torres Strait to the Northern Territory border to the New South Wales border. We are small, although we are not tiny. We have about 70 staff delivering those services across the state at this point.

At a personal level, mental health outcomes for Queenslanders are incredibly important. It is about quality of life. It is about participation in day-to-day life. At an economic level, good mental health outcomes are incredibly important. One of the things I would like to do today is focus in on some of the economics as well as the feedback that we hear from Queenslanders each day.

In focusing on the economic outcomes, I would like to highlight some words from the Productivity Commission that were made around 2010 when they were looking at establishing the National Disability Insurance Scheme. One of their clear findings and clear messages to government is it will cost you more to do nothing than to actually establish the NDIS. Their statements were motivated by the experience of many people who could not access an effective disability service, finding themselves being supported by the criminal justice system, the health system, the child protection system and others. They were people receiving inappropriate support at a higher cost than it would have cost government to deliver.

One of the things we would have liked to have given you is some firsthand advice from our senior project officer who runs our Indigenous services to share some of the experiences around the limited cultural competence of mainstream services for First Nations clients. That is one of the messages that we continually get, and I am sure Vanessa will add to that as we go through. Our submission outlines concerns regarding the need to improve mental health services to older people in residential and aged care and people with disability and disability services, particularly in the case of people with disability, those with a dual diagnosis of intellectual disability and a mental health issue. As a state we have invested in programs to regulate the use of restrictive practices to respond to some of the behaviours that people with a mental illness or people with a cognitive impairment express. I would like to talk through that we need to invest further in preventative and support programs rather than just responding to the behaviour at the end of the day. With the recent regulation of the use of restrictive practices in aged care we are seeing the various Queensland systems that are designed to protect older people fail them. I will not even go near the aged-care royal commission.

In summary, in my initial statement I wanted to really highlight two things: one, the issue of how the system supports people with impaired decision-making must feature in this review. We often hear that when people move into aged care they check in their rights and do not have any rights. With disability, unfortunately, we have a very strong state based rights based legislation that underpins the service and we are looking forward to seeing that also within the aged-care environment.

We have seen significantly the shift in Queensland over time around the implementation of the advanced health directive for mental health. If the committee are not familiar with that, I would encourage you to look at what that directive allows. It allows people who experience mental health issues when they are well to outline what care they would like when they are unwell.

Public Hearing—Inquiry into the opportunities to improve mental health outcomes for
Queenslanders

In the same way I would encourage the committee to look at our enduring powers of attorney, the very tools that are designed to protect people with a decision-making disability to see how they could be modified to better accommodate the needs of people with mental health issues but also how we can make sure those who are appointed as their attorneys understand their role and do not become their substitute decision-maker but, rather, their supported decision-maker.

Finally, I would encourage the committee, as part of my opening comments, to look at the big picture. Remember the words of the Productivity Commission: it will cost you more to do nothing than to do something. I remind you also that in Queensland we often look at the NDIS as a Commonwealth program. Queensland makes a significant investment in that program and as part of that investment we must also have a say in what the scheme looks like. We have seen lots in the media in recent times that say the NDIS is failing people, particularly people we see with psychosocial disability.

Investment is really required to support eligible people to participate in the programs that have been designed to support them. We see a lot of people who either do not know where to go for help or cannot actually access it because of the barriers in place. The month of May marks the end of a program that has been operating over the last 18 months, which was initiated by the Queensland government to support people with a disability, particularly the hard-to-reach people—people with a psychosocial disability—to access the NDIS because they kept falling at that first hurdle or were overwhelmed. The Targeted Outreach program has been very successful in getting thousands of eligible Queenslanders into the NDIS program. That program needs to continue beyond May this year so that those people continue to access appropriate supports and the supports they need.

Ms KING: Thank you both of you for being here today. Thank you for your advocacy on behalf of older Queenslanders and Queenslanders with disability every single day. I would like to ask you for further comment about older Queenslanders with mental illness. You note in your submission that there is an underprovision of services into residential aged-care facilities. For the benefit of the committee could you unpack a bit more what that looks like? What can the implications for an older person with mental illness be if they are not provided with mental health support in place at their residential aged-care facility or through home care if that is the support they are using at that time?

Mr Rowe: That is a big question. Thank you. What we know about the aged-care system is that most older people enter the aged-care system at a time of crisis. Instead of the due diligence that we would use or the decisions we would make about who is an appropriate provider, often it is about where can we get a place? There is a whole other story to be told about the number of older people we see who find themselves in a hospital bed and then are fast-tracked into aged care. We have taken that up previously, so I will not labour that point.

It has been a really interesting journey. About two or three years ago I did some research for a presentation around workforce planning. When I looked back 10 years prior, I saw that about 20 per cent of older people entering residential aged care had high or complex medical support needs, and that included mental health needs. If we fast forward 10 years, now 80 per cent of people going into aged care have high or complex medical support needs. In that 10-year period we have seen a total flip in terms of the demographic that are going there. Some of that is because people are staying at home longer. Some of it is that as people are living longer, we are seeing increased or more complex health needs including those of dementia.

What we have seen in the aged-care industry in that 10 years has been a move from a medical support model to a social support model. When we look back 10 years and think the health support needs were not that great then, they are really poor now. That is probably the politest way I can put it. There seems to be a culture that when someone is in receipt of aged care they no longer should have access, or do have access, to mainstream care services, particularly mental health services. If you think you can step into aged care and not be impacted by that change of environment from that crisis to the point of your life that has taken you there you are very much deluded. Time and time again we hear from older people who are struggling with that transition into aged care and their ability to access services. Particularly over the past two years with COVID many aged-care facilities, as you know, have been in lockdown. Their ability to leave the facility and go to a medical appointment has been complex and difficult. We often see that the provision of medical services is limited to the provider's preferred doctor, so people even lose their own healthcare professionals who have been supporting them.

It is a dilemma. It has been covered off in the aged care royal commission's report. If the committee is looking at that seriously I am really delighted. There is a significant proportion of people within residential aged care, people in home care, with similar issues but who are not as removed from that broader society. If you want to throw the word ageism in there, I think ageism is also one of the issues that we battle frequently. Older people are not seen as having value and therefore are not

worth the investment. My argument would be that the society we participate in now has been built by those older Australians and therefore we should respect and support them given what they have provided to us.

CHAIR: We seem to accept that people who go into aged care will inevitably deteriorate, so we give up almost rather than caring.

Dr ROWAN: Thank you also to Aged and Disability Australia for your submission and testimony today. Mr Rowe, in relation to some of the complexity for aged Queenslanders with mental illness and the intersection between the Guardianship and Administration Act—and I guess those who might also be managed under the Mental Health Act as well—we have recently seen some very harrowing scenarios with respect to things that were aired through *Four Corners* and the Public Trustee. Given that your organisation is involved in community advocacy and has a community legal centre and is managing the complexity of protections for that group of aged Queenslanders who have that comorbidity with mental illness and are being managed under multiple different bits of legislation, is there anything this select committee needs to look at to ensure protections for those people but also the operation of the system to make sure they get the care they need whilst also being protected?

Mr Rowe: I might ask Vanessa to answer that.

Ms Krulin: I would go through a couple of issues there, the first being that the intersection with the Guardianship and Administration Act is pivotal and it is pretty poorly understood by several intersecting sectors that an affected person will be touched by—certainly with respect to large sections of the aged care industry, certainly with respect to large sections of the Queensland Health system and hospitalisation system and certainly with respect to policing and other aspects. Unless you are really integrated in the system it is pretty difficult. These are complex issues and each person is different, so it is quite difficult.

Understanding the overlap between the definitions of decision-making capacity and how a person may be affected by mental illness, as Geoff said before, when a person is at a point of crisis and then undertaking a capacity assessment and how we then treat and triage that person. That was evident in some of the examples that *Four Corners* gave around not just the Public Trustee but every aspect of that system. There needs to be significantly more investment and understanding, and that is not just older persons. Obviously older persons are particularly affected by the guardianship and administration system, but it is not just older persons. There needs to be a more holistic approach.

Every submission that I have read in this inquiry—and certainly our submission—talks about the intersection of these issues. They are just never in isolation. There needs to be more investment in the intersection of the issues with the greater community and government organisations that are already doing the work with the federal government as well as the funding of QCAT so that when we get to the guardianship and administration system we are not rushing these issues through—not that they do. There is quite a delay to get an application before QCAT because they are really doing an incredible job on a very limited budget. It goes around.

Dr ROWAN: To clarify a couple of those things: streamlining of capacity definitions across legislation—

Ms Krulin: I would say a better understanding.

Dr ROWAN:—and education, and obviously investment and funding of QCAT.

Ms Krulin: Yes.

Ms PUGH: Thank you very much for your submission and appearing today. I am a ring-in to the committee. I just wanted to circle back to your comment, Mr Rowe—and I do not want to misquote you here—that people enter aged care at a point of crisis. I never really thought about it on a large scale before—only through my own personal experience—but it is a really salient point. That crisis where they are entering aged care, which is a traumatic and tricky time for any family as well as being time-consuming, does that then create a roll-on impact when they are starting their time in aged care that had not previously been there? Would there potentially be an impact on that person's mental health going forward for their experience in aged care, or would that issue already exist in your experience?

Mr Rowe: I think the journey into aged care is a very individual one. I have not met too many people who make the choice to go into aged care or residential aged care, although there certainly is a proportion of the population that does that. With regard to my comment around many people entering aged care at a time of crisis, it can be that the person's partner has died and they have been the primary carer for that person and suddenly they are without support, so they are dealing with grief and loss as well as a change of environment. Sometimes it has been an illness or injury that has

transitioned them there very quickly and once you are in that, particularly residential aged care, it is extraordinarily difficult to get people back from there even when they want to go back. Undoubtedly, there are people who go into aged care who have mental health issues prior to entering, but there are a lot of people we see for whom that has been really the initiator of the trauma they have experienced.

CHAIR: I want to deal with issues around people with disabilities, particularly people with intellectual disabilities. I know that, reflecting on my own practice as a nurse, we had a reasonably well-developed network of Indigenous liaison officers who did a really outstanding job of supporting non-Indigenous nurses and other health practitioners to work better with people. I have a background in working with adults with intellectual disabilities as well. I have noticed that other nurses, particularly who do not have experience with people with intellectual disabilities, sometimes do not necessarily know how to deliver appropriate care. Is there a need for more of those liaison roles for different populations like people with intellectual disabilities and perhaps other cultural groups out there?

Mr Rowe: I would certainly be supportive of that, but I would also encourage the trainers—whether it is the training of nurses or doctors—to include exposure to particularly intellectual disability as part of their training. It is probably heading towards 10 years ago when I was working for Endeavour Foundation that we brokered an arrangement with then Queensland university medical school where second-year trainee doctors had to go and support a person with an intellectual disability through their comprehensive annual health assessment. They had sit across the table from a doctor who was doing it really poorly. I suppose the role of the student was to make sure that the voice of that person with an intellectual disability was heard.

What we found as a result of that project was that people understood disability far more from that hands-on first experience. It demystified people with a disability; they were not someone with two heads and they were a person. While absolutely we can do better with what we have, I think we have to do work around making sure that our workforce is appropriately skilled when they hit the ground when they leave university, when they leave their training. When you are talking about Indigenous staff that is a really difficult one to impart that training and understanding. Certainly it is possible, but I think we also have to look at how we make sure that the people delivering the services are First Nations people so that they understand the trauma, they understand the story and they understand the culture.

Ms Krulin: I would just add that some of the direct feedback from our First Nations advocates who have direct contact with the space and some who have been involved in the space themselves talked about that drawing back into that systemic and policy level as well. The Indigenous liaison officers, for example, are critical. There should be more of them and they should be more widely available, but they cannot be the only aspect of that interaction. There was some criticism or some suggestions that from a policy and framework level this really needs to be revised and looked at from the First Nations perspective and have First Nations input rather than trying to bring it in just kind of at the ground level.

CHAIR: In your opening submissions you talked about that issue around limited cultural competence. The committee has heard evidence from particularly First Nations presenters around the issue of intergenerational trauma and really the trauma that is at the heart of the establishment of modern Australia. How do we make sure that rolling out cultural competence in key workforces is more than just tokenism? How do we make sure it is going to address the trauma that First Nations people feel?

Ms Krulin: To do that question justice I think it would be better for us to take that on notice so we could speak with our Indigenous staff about it.

CHAIR: Sure. No problem at all.

Dr MacMAHON: Thank you to both of you for being here today. Your submission notes that people with cognitive and psychosocial disability make up 50 per cent of people entering prison and you have noted the need for mandatory training programs. What other systemic measures could be put in place to reduce this number?

Ms Krulin: Are you speaking specifically about incarceration?

Dr MacMAHON: Yes, that is right.

Ms Krulin: There was some really interesting work that was being done under a section of Queensland Health about the wellness generally of prisoners. I am not sure where that program is at but it is so critical. The name that comes to me is Graham Clark as running it. Apart from the awareness aspect in Corrections, it is the awareness aspect in Police as well. Police are aware of that. We have been speaking with sections of the police to talk about education programs. As an

example, I have a client at the moment—I am limited to talk about it because they were before the tribunal—who has mental illnesses, is aware of mental illnesses and is also an Aboriginal person and has immediate, almost involuntary responses to seeing police and was institutionalised as a child. When this person is going through an episode of semi-manic periods, interactions with police have shown they are usually unable to recognise that intellectual disability and mental illness and there is the trajectory towards holding that person and the negative outcomes that come from there. There has been significant data and evidence on the use of solitary confinement in Queensland Corrections. It overwhelmingly shows that the use of solitary confinement will exacerbate mental illness. Prisoners' Legal Service would be my referral to you for further information.

Mr Rowe: If I can add a comment, when we look at the Indigenous legislation that we have in Queensland, one of the considerations is reasonable adjustment. We understand that when we talk about people's access to buildings—the physical accessibility or to transport—but I do not know that is necessarily translates into the mental health field, particularly with people with a disability. It is probably a wrong way of trying to connect it, but I would like to see the police system, the court system and the jail system being able to make some reasonable adjustments—that the person has an intellectual disability, that they have a mental or a psychiatric disability, and therefore some of the ways that people are managed and supported need to be adjusted so that they can appropriately respond.

Ms Krulin: To make an additional comment on that, it is very difficult to get feedback or insight into mental health conditions in the criminal justice system because of the cloistered way in which they are treated. I think the balance between the privacy implications of an individual and the public interest aspects are always difficult. A couple of years ago, the Queensland Ombudsman did an investigation into forensic orders of disability which, of course, we deal with a lot in our space. It was really interesting and telling. There is the odd case that will get to the Supreme Court that then is able to be published and looked into. Justice Applegarth put forward a decision in the case of a person who was, I believe, an Aboriginal person who had been born into circumstances which were of disadvantage and had gone through into the criminal justice system. Once they were in the corrections system, they were in solitary confinement and then court ordered programs were never delivered to that person because they were in solitary confinement. There was not the funding, resources and education to deal with the person's mental health behaviours. That person at some point may be released from the criminal justice system straight into the community.

Dr ROWAN: Throughout some of our earlier hearings we have had some discussions about adult mental health units within the public hospital system and the placement of certain cohorts of patients in there. Some of those are older persons, some with disabilities and some with intellectual disabilities—the complexity of different patients with different needs, all in the one mental health unit. There were some issues raised about human rights and also the vulnerabilities and risks of some of those people. Is there any information from an advocacy perspective, or through your network of liaising with other organisations, about recommendations for additional services, whether it be psychogeriatric or for those with intellectual disabilities?

As you mentioned before, there has been a lot of discussion about people who may have an intellectual disability and are on a forensic mental health order. I am really trying to glean any recommendations about service provision which is needed, or investment or infrastructure, particularly when we are talking about across Queensland because in the south-east corner there is a greater range of services. When we think of Metro North, they have a psychogeriatric unit. They typically have that service there as opposed to, say, Rockhampton or Mount Isa. Could you provide some thoughts about those particular cohorts? That is a broad question.

Mr Rowe: I would really like to go away to think about that and come back. Do you have some—

Ms Krulin: No, I think that is probably better. The only comment about the mental health units is that initial feedback would be in relation to when we are in matters before the Mental Health Review Tribunal. To give you a more fulsome answer, we would—

Dr ROWAN: I am very happy for you to take it on notice. Are there some specific recommendations from the advocacy sector about what could be done with service provision and infrastructure and, again, with that cohort of patients being older Queenslanders, so in that psychogeriatric cohort, and those with disabilities and particularly intellectual disabilities.

Mr Rowe: I am just picking up your word 'advocate'—I know we are probably trying to sell our own product, but I think having a person who is able to support and is independent of the system. We find time and time again that people get different places, having that independent person. Touching Brisbane

on my earlier comment around enduring powers of attorney, the confusion that we have with some of the more formalised support arrangements is that people do not understand the role and they will often make decisions in the best interests of the person rather than the sorts of decisions that that person would have made themselves. We will take that question on notice, thank you.

Mr MOLHOEK: Thank you so much for joining us today. There has been a lot of discussion in the services sector around labour force shortages and difficulty accessing local health specialists, particularly psychologists and counsellors. The upshot of that has been, I suspect, some of the home care service providers and disability service providers are perhaps consuming a lot of the packages that are on offer with administrative costs and servicing costs without actually getting access to the providers. I wonder if you are aware of that. Are you seeing an overservicing of home care packages for the aged and disability packages that is consuming the packages but limiting the ability or actually struggling to find the services that people need for mental health support, whether it be respite, programs, counselling or whatever?

Mr Rowe: I probably struggle saying that the admin fees impact the ability to access allied health professionals. Certainly we have seen, I think at its worst, about 60 per cent of a person's support package being used for admin fees by the organisation so that the person has really ended up with very few services. A lot of that is around personal care and home care. I am sure it does impact allied health, although I would make the comment that for an older person on a home care package it does not allow the funding of allied health professionals, full stop. Within a disability environment, absolutely they are eligible costs, and if you are fortunate enough to get that in your package then the hourly rate is set and you have some protection.

I would echo your concerns, though, regarding workforce shortages. We have heard lots in recent weeks particularly around aged care. As I think was said earlier, the further you get away from Brisbane the more difficulty there is to access particularly specialist care workers. How we deal with that I am not quite sure.

Mr MOLHOEK: Would it be fair to say that some clients are perhaps being rorted by service providers or being taken advantage of? You mentioned that one where 60 per cent of the package had been used. Do you think maybe those service costs should be capped as part of the total package?

Mr Rowe: I think that is an issue the NDIS is currently grappling with. Certainly within the aged-care sector we raised our concerns with the royal commission and with a number of other inquiries, and we know at the moment that the Commonwealth is looking at a new home care system with a due rollout date of 1 July 2023. 'Optimistic' may be too strong a word; we are hopeful that some of those issues will be addressed in that new home care arrangement. It comes back to my earlier comment that sometimes people do not have a lot of choice in terms of who their providers are—again, rural Queensland is a good example—but people do not always do their due diligence and the transparency within the systems has not been there. If we can do something to make them more transparent, that has to be a step in the right direction, where people are held accountable.

Mr MOLHOEK: I guess it would be fair to say that if you desperate to access a service—a little bit like when you are entering an aged-care home, you are at a point of crisis—you probably do not have the opportunity or perhaps the capacity sometimes to do that due diligence.

Mr Rowe: That is certainly true. Often in these forums I roll out a story about the current cohort of people. I will do that again. My apologies for those who have heard my story, but when I first started in the role at ADA I asked my staff to tell me about the current cohort of people we were supporting, particularly in aged care. They described them as the grateful generation—a generation who is reluctant to complain, who have grown up through the war, who have put up with stuff and are fairly stoic.

What we do know about aged care is that that grateful generation are now moving on and we are starting to see the baby boomer generation move into aged care. No-one has ever described the baby boomers as grateful. When they have seen things they do not like, they change. Whether you want to look at childbirth and go back to when I was born, my dad stayed at home and waited for the call. Nowadays, you can have everyone you want to have in the birthing suite, COVID excluded. Why did that change? Because the expectation of the cohort has changed. I think that is one of the things that we as an advocacy organisation, but I think also government as a provider of services, need to move away from: 'this cohort of people are older people'. Maybe it is that the cohort of people we are now seeing moving into aged care are older people, but they are older people with attitude and older people who will not put up with what their parents did. Their expectations will be different and, to an extent, some of them will also be cashed up. Maybe they have a way of influencing, too.

Mr MOLHOEK: Or choice.

Mr Rowe: Or choice.

Ms CAMM: Thank you, Mr Rowe, for being here. I have disclosed to the committee before that I care for an aunty in her sixties with a significant intellectual disability who has a fantastic package under the NDIS, but in a rural community the challenge—and I am interested to see if you have seen this in your advocacy work or engagement—is the shift from group provision, which was the traditional setting, to now more individualised support where we will have five or six different carers over the course of one week. We will have a coordinator who is with all of the allied health—occupational therapy, counselling et cetera, and she is also on a mental health plan—all of those things. In some cases—and I have spoken to other carers—it is actually sometimes creating more mental stress and anguish over the shift from what was a group setting, where there was an ability to socialise and connect, to now this one-on-one individual support, which is fantastic for those who want it. We are also seeing providers pop up in rural and regional communities—brand new buildings, brand new tenancies and brand new services that I have never heard of under the NDIS. What are you hearing in terms of trends there? In my personal experience, it has impacted her mental health in a negative way more than a positive way because of the significant change in the way services are being provided. Do you have any experience or have you heard any stories like that?

Mr Rowe: It is complex. Disability has worked very hard to move away from the medical model of care and I think in the process has at times adopted a philosophy that is not necessarily the philosophy that individuals who are supported by the system want to be supported under. From my perspective it is about having a menu of options—a range of choices. When we all go to buy a service, we try to buy a service that meets our needs.

If we look at the death of Ann Mary Smith in South Australia, there was one carer involved. Single-care arrangements are problematic and should never happen. Should people with a disability have friends with a disability? They should have the friends they want to have and socialise with whomever they want to. We need to make sure that we listen to what the person with the disability is saying about what their choice is and preference is. This comes back to a statement that was made to me many years ago. We need to have a menu of options that people with a disability can seek and apply for.

I have been around long enough and was one of the people who lobbied for the establishment of the NDIS many years ago. Has it delivered everything that we wanted? No, it has not. I think it has fallen short and has lost its way in some areas. Has it improved the lives of people with a disability? For many people with a disability, absolutely. I guess it comes back to the fact that ideally people should have the opportunity to participate in the community and be a member of the community—whether it is somebody with a disability, whether it is an older person, whether it is you or me. Human rights are not different for different people or should not be different for different people. Human rights are there and we should all be able to access them. Did you want to add to that?

Ms Krulin: I cannot add to that. I think that was spot-on.

Ms CAMM: Do you believe there is adequate advocacy for people with disability and in aged care across rural and regional Queensland?

Mr Rowe: Absolutely not is the short answer. Aged-care advocacy and disability advocacy operate from two different models. Aged-care advocacy is funded by the Commonwealth government and back in 2017-18 they decided to fund one organisation nationally to deliver a nationally consistent program. ADA Australia is a member of OPAN—the Older Persons Advocacy Network—which holds the contract with the Department of Health.

Disability advocacy is funded by the Commonwealth and state governments. There are lots of small organisations scattered around the country. It is a bit of a lucky dip if you live in an area which is serviced by one of those organisations. The reform that the Queensland government has recently undertaken around funding of disability advocacy has attempted to provide a statewide coverage, but that attempt has been done using the same pot of money that was available historically.

To put it in context, the new First Nations service Side by Side is funded for \$300,000 to provide a statewide service to Indigenous Queenslanders with a disability. It is a bold move. We are struggling to deliver the outcomes that we need to deliver, particularly with such a vulnerable cohort. I think we could do a lot of better. I am saying 'we' as a society. As advocacy organisations I think we can probably do better in terms of being less adversarial and trying to work with government and with people to get those better outcomes for those marginalised people.

Public Hearing—Inquiry into the opportunities to improve mental health outcomes for
Queenslanders

CHAIR: I thank you very much for your submission and your presentation today. It will be very useful to the committee as we move forward. There were a couple of questions taken on notice and we would ask that you have responses back to us by the close of business on 26 April.

Mr Rowe: Thank you again for the opportunity.

MURRAY, Ms Susan OAM, Managing Director, Zero Suicide Institute of Australasia

CHAIR: Ms Murray, I ask you to make a brief opening statement and then we will go to the committee for questions.

Ms Murray: Certainly. Thank you very much for the opportunity. The Zero Suicide Institute of Australasia is an advocacy organisation that is seeking to raise the profile of the Zero Suicide Healthcare framework and Crisis Now framework, both under the auspices of a restorative, just culture. We work with healthcare systems to look at continuous quality improvement in the delivery of mental healthcare services and for people presenting with suicidality.

I want to look at mental health reform as well as suicide prevention in my opening statement. Like a physical health crisis, a mental health crisis can have a devastating effect for individuals, families and whole communities. Often that experience is met with situations that might be delayed, where people might be detained—and I am sure you would have heard many examples throughout this inquiry—and even denial of services. While we certainly cannot plan a crisis, we can plan the way in which services are managed and presented in order to respond to the individuals who present in distress. Those services need to be available everywhere for every person every time they are needed.

I profiled in the submission the Crisis Now model of support for those who present with a mental health crisis. That model of care is an integrated program of services that provides for individuals to present to a service that meets their needs at that point in time. It begins with a technology hub and that technology hub is staffed by health professionals. People call into the technology hub. The evidence suggests that up to 90 per cent of all crises are de-escalated at that point. For those who are not de-escalated through the work at the crisis hub, there is the ability for mobile services to be dispatched. Those mobile services will meet the person at a place of their choosing. That has been demonstrated to support probably 75 per cent of those who are seeking the outreach service. For those who are not serviced by the hub or the outreach services, the stabilisation centres present a home-like environment where people are able to remain, to de-escalate and to have an assessment if they are needing further inpatient services.

Underpinning all of those are the principles and practices of the Zero Suicide Healthcare framework. What is a critical part of every part of that pathway is that they are joined up by technology. Technology ensures that the story from the entry point into the hub continues through with that person wherever they may present to services. The integration of services and the communication means that the individual is not needing to share their story over and over again which, as we know, can often be retraumatising and is also about ensuring a smooth transition. I am sure you have heard that one of the critical parts of our whole mental healthcare system—if you can describe it as a system—is that those transition periods are periods of extreme risk for individuals.

The Crisis Now model has the ability to divert people away from emergency departments and jail. It eliminates wait times in EDs by giving immediate access to care because it is available outside EDs. It reduces the time away from community safety for police because there is a 'no wrong door' policy at the stabilisation centres. There have been demonstrated reductions in costs of around 40 to 45 per cent. It is a model of care that could make a significant difference to the individuals who are presenting to health services in a mental health crisis.

CHAIR: You suggest in your opening statement that there is evidence related to the process or the steps you outlined. Where is evidence drawn from?

Ms Murray: This is a US model and it has been demonstrated in several areas across the US to have had cost savings, improvements in care for individuals as well as improvements for health services because they operate under a restorative, just model.

CHAIR: Are we able to get some of that information?

Ms Murray: Sure.

CHAIR: From a conceptual perspective it seems like a fairly logical approach. You talk about the technology hub and achieving 90 per cent de-escalation through phone calls—or Zoom, I guess, these days. How is that different to what is currently available through, say, Lifeline or those sorts of services?

Ms Murray: The hub is staffed by health professionals. That is the big difference. They are skilled in de-escalation. It is a mental health service so they are mental health crisis workers.

CHAIR: What is the way that a person who is contemplating suiciding gets connected through to that service? What is the motivation for that person to ring rather than to end their life?

Ms Murray: That is the sixty-four dollar question. One of the things we do know is that suicide crisis can be a very short period of time: it can be five minutes; it can be 30 minutes. It is a mechanism by which that intent to take one's own life is interrupted. That could be any range of systems. Both the Zero Suicide Healthcare framework and the Crisis Now framework are about people presenting. People know about the services and they present to the service.

We know that about 20 per cent of all suicides are people who have been in touch with our healthcare services. The four in five we do not know about. We do not know who they are. Our ability to interrupt that behaviour is at best good luck. For people who are presenting to health services we have a much better ability to work with those individuals and ensure they are managed and supported in a way that they feel safe and are discharged back into community services where there is a wraparound approach to support those individuals.

CHAIR: My next two questions are along the lines of the first one. You said that 75 per cent of people you outreach to can be diverted away from suicide. That is a good statistic. We currently have co-responder models with the Queensland Ambulance Service and Queensland Police Service, both working with mental health professionals. Are they the sorts of services you are envisaging or is there something else?

Ms Murray: That would be an example of the type of service, so long as there is a mental healthcare professional attached.

CHAIR: A lot of hospitals are exploring or have established crisis support centres. Is that the sort of thing you are anticipating or is this something else?

Ms Murray: It is that type of approach. The stabilisation centres probably are able to manage higher throughput than the crisis care centres as they are being established at the moment and they are attached to hospitals. The stabilisation centres do not necessarily need to be attached or are not necessarily attached to hospitals. In some instances in the States they are, but in many instances they are not. They do have health professionals attached to stabilisation centres. While it might be a peer-first peer-last entry and exit from the stabilisation centres, there are health professionals who have the ability to provide prescription medication if that is required, there are psychological services and even access to psychiatry services, if those services are required. It is an important differential from the push we have at the moment to a non-medicalised environment. The environment is non-medicalised but the support structures are in place.

CHAIR: That is interesting, because other groups have come along talking about safe spaces. One of the questions that has always been in my mind is: if I am a police officer, paramedic or nurse and I have someone under my care, handing the care of that individual over to somebody who is not a professional would be tricky from a liability perspective, I feel. You talked about the need for three elements—the technology hub, the outreach and the stabilisation centre—to be connected via technology so that people's stories follow them. That is probably not happening at the present time—not officially, anyway. We tried with My Health Record.

Ms Murray: That is really a very challenging aspect. I am based in New South Wales, and I know of one hospital where there is one system used in one part of the hospital and another system used in another part of the hospital, so when the person transfers out of ICU into the general hospital there is not a piece of communication that informs the general hospital about that person's circumstances.

CHAIR: Only two systems? That is pretty good. That is a lot better than where I worked. I will go to the deputy chair for a question.

Mr MOLHOEK: I do not have many questions. You touched on My Health Record or the system that Queensland Health uses in hospitals. Is that not readily accessible so that when a person moves from one area of the hospital to another they can track their background? What has been happening?

Ms Murray: I cannot answer that question in relation to Queensland. That was just an example of a New South Wales hospital I am aware of where there are two systems within one hospital.

CHAIR: That would be a great question for us to put to Queensland Health. I think one of the biggest challenges with My Health Record is that it is voluntary and opt-in, and not many people have opted in.

Mr MOLHOEK: I cannot remember the system that Queensland Health uses, which I think we heard through the health inquiry is now being used to share information with GPs. Regardless of which system it is, it would seem important that they are able to track people through the system.

Public Hearing—Inquiry into the opportunities to improve mental health outcomes for
Queenslanders

Ms Murray: I did just have a discussion, prior to coming here, with Queensland Health. They do have capacity for information to be shared with other agencies—not widely, but they can be identified agencies and they can view the information. There is capacity in Queensland to have some sharing of information, yes, but whether that extends to the police I am not sure. Ambulance, yes.

Dr ROWAN: In relation to mobile crisis workers, can I clarify the knowledge, skills and training that those people would have to fulfil those roles? Would that be standard or recommended that it be standardised across the board?

Ms Murray: They are healthcare professionals—sometimes a healthcare professional and peer worker but trained, yes. That would definitely be a recommended approach. As we know now, particularly for police who get called out to an ad hoc incident in the community, when they have no training whatsoever it can be very difficult for them, particularly if someone is in a psychotic state.

Dr ROWAN: You could have someone who is a mobile crisis worker who might have a social work background—a peer support worker?

Ms Murray: Yes. Some health professional training, yes.

Dr ROWAN: With additional training to do that?

Ms Murray: With additional training to support mental health, yes.

Ms KING: Thank you so much for being here today and for your presentation. As the chair alluded to, we have heard from other suicide advocacy groups that have strongly pursued a view that suicide should be treated entirely non-clinically. I note the evidence we have received as a committee about the fact that, of people who commit suicide, around only 50 per cent are diagnosed with a mental health disorder. That always leaves me with the question about the 50 per cent who do not. There will also, presumably, be a degree of underdiagnosis among the 50 per cent who do not have a diagnosis at the time of their suicide. You have mentioned that your model sees a role for the clinical workforce in responding to suicide attempts or suicidality. I wonder if you could unpack that a little bit more and comment about the peer workforce and how you see those things working together.

Ms Murray: There are seven elements to the Zero Suicide framework. Leadership, training and continuous quality improvement are three of those elements; the remaining four relate to the suicide care pathway. One of the critical changes that has happened over fairly recent years, maybe the last decade or so, is that there is very clear evidence that when people present to health services with suicidality that suicidality should be treated directly and not as a by-product of a possible mental health diagnosis. In a sense, that deals with people who may not have a mental illness or mental ill health. Anyone who is presenting with suicidality has a state of mental distress that does not necessarily need to be alleviated through medication. The pathway really seeks to identify what has happened to a person and why they have presented at this point in time with suicidal behaviours. Through that exploratory process health professionals will come to an understanding of whether there are psychosocial needs or whether there are clinical needs for that individual, and then the pathway is designed to support them appropriately.

I do not think I can make a blanket statement that we should not be treating suicidality in a medical environment and we should only be treating it in a non-medical environment. It is the exploration with the individual and the design of the care plan that then really governs the pathway through which they will be supported. Some of that will be treatment inpatient care, some of it will be treatment with medication and for others it will be treatment through psychosocial supports. I would really hesitate to say that there is one way or t'other. It is really very much what has brought the individual to that point in time that really needs to be explored and managed.

Dr MacMAHON: I am interested to know whether there are any parts of Australia that are implementing a model close to this or similar to this and whether you think this would be best delivered by organisations that are funded by government or best delivered through Queensland Health, for example.

Ms Murray: The entire model, no. We have elements of the model in place and we have a lot of advocacy work that has been done with the Commonwealth government and state governments to look at a much better integrated approach; however, the first of the urgent healthcare centres has been established in South Australia. It is funded through the Commonwealth government under one of the adult mental healthcare centres.

I think the best example is probably here on the Gold Coast. The Gold Coast has implemented the Zero Suicide Healthcare framework with great fidelity. I am sure that, if you have not already, you will hear from Dr Kathryn Turner at some point. I think Kathryn is now at South Brisbane, but she was on the Gold Coast and is the clinical leader who really took the framework and applied it with great Brisbane

fidelity, recognising that there was also a need to look at people who were attending in crisis care but not needing to go into their inpatient services. Also under Kathryn's leadership before she left the Gold Coast was the establishment of a stabilisation centre.

The Gold Coast probably is the closest because they have the principles of Zero Suicide Healthcare well and truly embedded in their practices. They have a restorative, just culture as a critical component of the way their health service operates and they have a stabilisation unit which is attached to their health service. They did put it onsite. They wanted to have it offsite, but other things came into play. I think that opened in November last year, so it might be well worth having a look at how both the Gold Coast specialist mental health service and their stabilisation centres are operating.

What we do not have is a central hub. We do not have that place that is connected to all other services. I think that is the really critical part, because so much can be achieved by de-escalation at that single point. That brings up the other whole huge challenge of the workforce: how do you find and build the workforce that is needed to deliver these types of services?

Dr MacMAHON: What do you think would be the funding estimate to implement a model like this across the state?

Ms Murray: I can tell you what they invested in the United States and then what it saved them. For a \$100 million investment they saved \$265 million in a year. That takes into account the time for police being not required to sit with someone they bring in. It took into account all of the other aspects—not just the dollar investment but the time investment as well. I believe the investment in the adult mental health hubs is somewhere between \$8 million and \$12 million, so that might be an indication of what South Australia has invested. The Gold Coast, I think you will find, is a HHS and Gold Coast hospital investment, so again it might be worth exploring that in a little more detail with the Gold Coast.

CHAIR: Can we have any data on those figures you referred to from the United States, if you have any documentation in relation to that?

Ms Murray: I have a business case which I can always table.

CHAIR: Which particular state is it?

Ms Murray: The business case is built out of Arizona and Georgia, I think.

Ms PUGH: I have not attended previous hearings; I am a substitute today. Fifty per cent of people who commit suicide or have suicidal ideation have previous mental health issues and diagnoses and 50 per cent do not. My personal family experience is that a traumatic life event resulted in suicide following very quickly. That is a significant cohort of all suicides. Where that person has not previously engaged with any mental health services and therefore they do not have that connection with the services they need, how can we identify and direct them? What education pieces can we do in the government space to help family and friends make sure people are connected to the services they need? There is a significant cohort who may not even be exposed to good mental health services or even be in contact with a primary care provider prior to that traumatic event.

Ms Murray: My role is focused on the healthcare service, and the reason I do that is that when people present to a healthcare service we know who they are because we have a thing called Medicare, so we can identify the individuals and therefore should be able to follow them. However, Zero Suicide Healthcare as a framework is designed for the health system, but the principles should equally apply where there is any network of people who might be trained to understand suicidal behaviour and then to understand that, first and foremost, listening with an open heart and mind is what you really need confidence in doing. If someone presents to you with suicidal behaviours, your first reaction is to want to respond and help, but in fact the first reaction from people should be to sit and listen and de-escalate that situation. Each of us has two ears, two eyes and a mouth. We can sit and listen and support that individual.

There are many programs operating at the community level that are important in terms of educating family, workplaces and the wider community about suicidality and supporting individuals who are suicidal. One of the most longstanding and evidence based programs would be the LivingWorks suite of programs. You may have heard of safeTALK. You may have heard of ASIST. These are programs that are designed to strengthen community capability in the prevention of suicide. Zero Suicide operates as a complementary framework to those broader initiatives which are in the wider community, but there are many programs that are out in the community. Within the Zero Suicide framework a critical part of engagement, which is one of the elements, is to ensure that family or the support network the individual may choose is brought into discussions around planning for their care pathway.

Public Hearing—Inquiry into the opportunities to improve mental health outcomes for
Queenslanders

CHAIR: Thank you very much for your submission and thank you for your presentation this afternoon. It has been very useful for the committee. If you have made the trip up from New South Wales, we doubly thank you. You have taken a couple of questions on notice. We would like the responses to those by close of business on 26 April.

Ms Murray: Yes. I also have a document titled 'International Declaration for Mental Health Crisis Care', which I would like to table. I also have included a diagrammatic of the outline I have explained to you today and the benefits of how each stage reduces the people who need to go into inpatient care. If I may, I will leave those with you.

CHAIR: Certainly. We will gladly accept those. Thank you for tabling them.

Proceedings suspended from 1.18 pm to 1.47 pm.

CHESTERMAN, Dr John, Public Advocate

MARTELL, Ms Tracey, Acting Manager, Office of the Public Advocate

CHAIR: Welcome. I invite you to make a short opening statement and then we will go to the committee for questions.

Dr Chesterman: I begin by thanking members of the committee for inviting me here today. I acknowledge that I am speaking on the traditional lands of the Jagera and Turrbal peoples and pay my respects to elders past, present and emerging.

As members of the committee know, I began my term as Public Advocate in August last year. The submission to this committee from my office is part of a longer report on Queensland's acute mental health system on which my office is partnering with Professor Neeraj Gill. That is due for completion in June. I will, with the committee's indulgence, make a few introductory comments before welcoming comments and questions.

As members know, the submission from my office identified a number of areas in which reform opportunities exist for the acute mental health system in Queensland. I point here briefly to seven key areas in which this might occur. The first is improving the system's first response to a mental health crisis presentation in the community which includes additional training for Queensland Ambulance Service officers, the availability of alternative crisis care pathways and improvements to information sharing amongst first responder services. The second is improving the experience of mental health patients in emergency departments, including by creating greater diversionary options to limit the escalation of conditions. The third is reviewing the locked ward policy employed at all authorised mental health facilities. This policy is not aligned with the Human Rights Act 2019 or the Convention on the Rights of Persons with Disabilities and actively discourages people with acute conditions from voluntarily seeking treatment.

The fourth area is improving the assessment and treatment of dual-diagnosis patients—for instance, people with a mental health condition and intellectual disability. The fifth is requiring the recording of Mental Health Review Tribunal proceedings. The sixth is better integration of the role of the independent patient rights adviser in the acute mental health system. Finally, it is to improve discharge planning by partnering with patients, their families, substitute decision-makers and support persons to develop improved individual discharge plans.

If there is time at the end of this session, I would like briefly to make a further comment about the forensic disability system. I will end my preliminary comments there. I welcome questions and comments. Thank you again for having us here today.

CHAIR: The list that you read out is what you are working on at the moment and will come out later this year—in June, did you say?

Dr Chesterman: Yes.

CHAIR: We have received a significant number of submissions from people with lived experience. Many of those people raise issues around their treatment, particularly during their time as inpatients, or their experiences of interacting with the police, the Ambulance Service and emergency departments of public hospitals. Are there things we can do to improve the responsiveness of the system in assessing people's complaints and improving the system?

Dr Chesterman: Yes. That is an important and big question. Obviously the first response there is to look at other precautionary measures which mean people are not involved at the pointy end of the mental health system. It is an important point to observe that you have heard from people with lived experience of mental illness, because they are the ones I would be turning to first to ask, 'What would improve things from your perspective?'

I know from the research done by Sandra Smith from my office, in preparing the work she is doing now, that one of the things people say is that emergency departments are antitherapeutic environments. We know that. There are things that can be done to improve those. There are some interesting innovations that are happening in various places. One I know of is the Urgent Mental Health Care Centre in Adelaide which is a very therapeutic environment. I know that we have had on the Gold Coast a similar effort with a crisis stabilisation unit. I think that has moved a little from its original intentions.

Looking at more therapeutic environments but also the training of first responders is what we would point to. The Ambulance Service does an important job here. In terms of improvement opportunities, we would look to further training that ambulance officers could be provided. We know that the Queensland Police Service is a first responder. We would look to further training that police might receive. You heard this morning about some of the training that is provided to police in relation

to mental health responses. One thing we would say, and have said in our submission, is that the police are not trained to give a health response, although in essence they are tantamount to providing one at that first port of call.

There are a range of areas that we touch on where the system could be improved. The big-picture solution to that is reducing the need for people to present at that pointy end of the system and have better diversionary and precautionary options available.

CHAIR: I am interested in the discharge planning issue. What are the steps that we can take to improve discharge planning from your perspective?

Dr Chesterman: Improvements would involve fairly clearly and plainly explaining what the obligations are on patients following their discharge and providing information to them, their families, substitute decision-makers if they are in place or support persons if they are in place about ongoing community treatment that is required. We would say that discharge plans should also include information on how to link in to services that are appropriate that will assist with a person's safe discharge, work to prevent readmission and promote better health outcomes for patients and their families. It is an obvious point to make too, though, that the unavailability of appropriate support upon a person's discharge would lead to them either being discharged into the community without adequate supports, which places them at risk of deterioration, or lengthening the time they remain in an authorised mental health service because there are not services to be provided to them.

CHAIR: One of the big challenges—and I have done a reasonable amount of discharge planning and management over the years, but not in mental health—is patient compliance. We set up beautiful discharge plans, all the services are in place and people go home and cancel everything we put in place. I imagine that would be a challenge in mental health services as well. Do you have any thoughts about how we improve compliance when we do get discharge planning right?

Dr Chesterman: There are no groundbreaking ideas from me on that score other than to say that compliance will be higher where a person has buy-in to the plan—that is, where it is more like a negotiated agreement and less like a case of 'here you go'. I would say that a person is more likely to comply in that case.

CHAIR: I want to come to the statements you made around the use of locked doors et cetera. I know in the non-mental health space we commonly physically and chemically restrained people up until reasonably recently. I am not sure about the private sector, but in the public sector now our solution to patients with challenging and problematic behaviour is one-on-one support from an assistant nurse usually. It is an expensive approach and not always as smooth as you would like it to be. What are the alternatives to that in a mental health setting?

Dr Chesterman: From first principles, having a policy of locked wards to my mind is not consistent with our human rights and convention obligations. I make that point. Then how do we ensure clinically appropriate treatment that does not result in risks to the person, to staff members and to other members of the community? That is a very important question. We do not want to see wards suddenly become unlocked. When I say 'unlocked' I mean for voluntary patients, not involuntary patients obviously. We do not want to suddenly see a spike in restrictive practices usage that could accompany any removal of the locked wards policy.

I do not have a generic response to that question other than to say that we need to evaluate individuals. One of the problems with the locked ward policy is that it does treat all mental health patients the same way and as though they all constitute the same risk. I know from a clinical perspective that that posits the staff as custodians or guards rather than therapists. Following that line of thought, we need to be assessing and treating individual risks as individual risks and finding appropriate responses. I know that does not answer the question in a broad sense, but I want to move away from a generic response.

CHAIR: So you are saying that in these locked wards there are voluntary and involuntary patients so there are regulated and unregulated patients?

Dr Chesterman: Could you repeat that question?

CHAIR: There are voluntary and involuntary patients in the same space?

Dr Chesterman: Yes, and that is the problem. That is where it is not consistent with our human rights obligations, because people who are under involuntary orders have had a process or are subject to a process where the voluntary ones are not.

Dr ROWAN: I wanted to come to improving the assessment and treatment of dual-diagnosis patients—those with intellectual disability and mental health conditions. There has been some consideration and testimony around having a dedicated tertiary service unit, I guess to try to have

some of these patients out of adult mental health units. At the moment they are placed there and there have been concerns raised in relation to human rights and also those patients being with other cohorts of patients in those adult mental health units. Is there anything that you would recommend from your experience or advocacy with respect to a dedicated, funded unit and, if so, any ideas of size, how many beds or infrastructure that would be needed for that?

Dr Chesterman: Thank you for that question. It is an important one. I have seen some discussion about the idea of that dedicated unit and I think that is a great idea. As to the modelling of numbers of people, I do not have that figure. When we are talking about people with dual diagnosis, it would be more like the tens and hundreds rather than thousands, but I do not have a figure to hand.

I would say that the assessment and treatment of people who have a dual diagnosis, if they are in the mental health system, will tend to be through the lens of mental health in the way that if we think of other people with other dual diagnoses in other systems—in our submission we talk about if someone presents with a stroke or another physical condition like a broken bone who has symptoms of mental illness, you would call in the consultant psychiatrist to assist. We tend not to do that the other way around, when people are in the mental health system. I think a dedicated unit would be very important. This problem is even more pronounced—and I will come later on if there is time to talk about it—in the forensic disability system.

Dr ROWAN: I want to come to that as a follow-on question around the Forensic Disability Service. There was some public commentary recently about the former director and interference in their role as a statutory officer in relation to the Forensic Disability Service, which I understand is a 10-bed, medium secure unit. The Queensland Ombudsman found in 2019 that administrative decisions of the department of communities, disability services and seniors at that time had impacted on the capacity of that statutory office holder to discharge their obligations under the Forensic Disability Act. Should that entire service be within Queensland Health and under the Chief Psychiatrist, or is it appropriately located within the department of communities and disability services? There is obviously a shared responsibility of caring for people with disability needs but also providing mental health oversight and input, particularly when people are on supervised leave within the community and even transitioning back into community care.

Dr Chesterman: If people do not have a mental illness they ought not be under the governance of mental health officials as a broad principle. As you would know and as we mentioned in our submission, a complex interplay exists with the forensic disability and forensic mental health system at the moment. People would know that the Mental Health Court can make forensic orders (mental health) and forensic orders (disability). As in the 2019 report, there is also a 2018 Ogloff report on this topic which mentions that most people under the forensic order (disability)—which is currently in excess of 100 people—are managed by authorised mental health services despite tending not to have mental illness, which is kind of bizarre. As you would also know, there is only a very small number of people who are actually at the dedicated Forensic Disability Service, which only has 10 beds. A series of reports has called for operational and governance reforms in that area, which I would simply endorse.

Mrs McMAHON: I want to have a quick check on some of the issues raised in your submission. The first is issues in relation to the 1300 MH CALL line. Your submission stated that, while it created efficiencies for Queensland Health, it limited the ability of community based organisations to assist people to seek care. Could you step us through how what appears on the surface to be an efficiency is actually potentially a barrier?

Dr Chesterman: I will look to my colleague to prompt my thoughts on this. I do not want to go off script but, Tracey, would you like to comment?

Ms Martell: What we have been informed by stakeholders we have been consulting in relation to this report is that the introduction of the MH CALL service operated by the acute mental healthcare team has restricted the ability to walk in, in person. Often people with a mental health condition require a support person to assist them in coming forward to voluntarily seek treatment. The call service means that the ability of a person to walk in and visit an acute mental health nurse with a person with a mental health condition is curtailed. The only option they have is to call the MH CALL service, which does not allow the support person to provide that person's story or context to the acute mental health team.

Mrs McMAHON: The other aspect I want to look at is the information-sharing provisions mentioned in your submission at 1.4. Have there been any coronial findings or court findings in relation to some of these information-sharing provisions? I note you look at the link between mental health, domestic and family violence, and homicide. Noting that we have had submissions particularly Brisbane

from the QPS in that their PCC, their call centre, is now staffed 18 hours a day with someone who has access to the mental health database specifically, where could these information-sharing provisions be bolstered by government?

Dr Chesterman: Thanks for that question; it is an important one. In this area—and this applies to information sharing in other areas of the broadly defined social support system—it is often unclear whether the problems are legislative or due to the interpretation of existing laws. All we are reflecting in our submission is the view that has been put to us by the agencies with whom we have spoken that this is a barrier. This is a complex area because you do not want a person whose every instance of mental illness is somehow reported to police. At the same time, we have heard that there are significant community concerns where someone has been involved in the domestic and family violence space and has had a long history that would have been relevant to any interventions in that space but that is simply not known. We want to get the balance right there. All I would be doing is encouraging you to take a look at whether we have that balance right at the moment and where the problem is. If it is legislative, there is a potential solution there. However, if it is more in the field of interpretation, that is a community and service educational challenge as to what you can actually share.

Mrs McMAHON: In your role as Public Advocate, going back to the QPS project which has a Queensland Health member working within the Police Call Centre, do you see that as a good initial first step in that information-sharing provision, noting that the information stays under the ownership of Queensland Health, not Queensland Police? How do you as an advocate balance the privacy issues with the operational necessity for first responders to have all the information at their fingertips?

Dr Chesterman: It is a great question. It is difficult to answer in general. The principle is that the information has to be germane. I think having the Queensland Health person there is a good step, because you do retain that ownership and division. Ensuring that information transfer is germane to the issue at play is going to be central. Whether it is proximate enough and relevant enough is the broad principle. How you operationalise that is more difficult. You have to make sure there are reviews in place to see whether information is being, for instance, shared too readily on a risk-averse basis. That does not answer the specifics, but the guiding principle should be that it has to be of close enough proximity to the issue at play, the risk presented.

Mrs McMAHON: I imagine that would be covered under protocols for that person who is embedded within the PCC.

Dr Chesterman: Indeed, and review of what they have done to ensure it is consistent with the protocols.

Mrs McMAHON: Have you had any feedback in relation to that role or that particular information-sharing provision within QPS and Queensland Health?

Dr Chesterman: I do not believe we have had specific feedback in relation to that role within QPS, just the broader issue.

CHAIR: It is an interesting area. We have the national My Health Record, which was our last attempt to share data on a fairly large scale, and that is unfortunately not working the way we hoped it would work. It sounds like there is more work we could do internally at a state based agency level.

Ms CAMM: You outlined patients' and families' right to question assessments and recommendations. My interest is in rural and regional settings. You quoted Ryan's Rule. In my local community and in other parts of regional Queensland, when you ask for a second opinion the second opinion comes from the exact same physician or specialist. What is the prevalence and the demand and also in the context of parents with adolescents or those patient privacy provisions that exist? Do you have any further comments to expand upon how that could better be addressed?

Dr Chesterman: My role is in relation to adults, and different considerations come into play with children.

Ms CAMM: Ignore that bit then and talk about adults or other carers or other family members.

Dr Chesterman: We still have adults who have parents who are involved in their adult children's care and support. Where the person is acting in accord with the wishes of the individual—so if we imagine an adult who has their mother involved and that person wants their mother involved, it is important to respect her right to be involved, to communicate information and to seek information on behalf of her adult son in that example. The issue raised in relation to people in regional and remote areas is a very real one. That is a safeguard that essentially does not exist. Where a second opinion is coming from the same person, we need to improve that and provide a meaningful recourse to what is a legislative safeguard.

Public Hearing—Inquiry into the opportunities to improve mental health outcomes for
Queenslanders

Dr ROWAN: In relation to advocating for system reform with respect to impaired decision-making ability and the intersection between the Guardianship and Administration Act and the Mental Health Act 2016, which has now been in effect for five years, are there any emerging issues or trends? Do you have any thoughts or recommendations that would have applicability for the mental health system moving forward and specifically any commentary that the committee could make in its report eventually that would improve the interaction between those two pieces of important legislation?

Dr Chesterman: My view is that I have questions rather than answers on coming into this role. One of those is a question I have been asking. If QCAT appoints someone as a guardian, they do that because the criteria around need for a decision-maker has been met. I have a question around whether and the extent to which decisions by guardians are being made, for instance, to consent to mental health treatment which means that in effect the involuntary processes are not followed.

There can be some situations—I know that it does happen. The Public Guardian, for instance, can be appointed and may make a treatment decision. But for making that treatment decision, the person may have been then subjected to the involuntary treatment process. My question is: how often does that happen? I am not sure of the answer to that. We would know with the Public Guardian but there are private guardians as well, so we do not know how often that happens. In fact, in my tours around Queensland I have been asking psychiatrists the extent to which that is utilised.

I have a considerable concern if that is being used, particularly not by guardians so much but by people appointed either as attorneys under the powers of attorney legislation or, even more importantly, statutory health attorneys because a statutory health attorney is not appointed by the individual; it is an automatic role played by someone in the hierarchy. If we were seeing statutory health attorneys making mental health treatment decisions and but for those decisions the person would have been in the involuntary process, that would cause concern to me because they have not been appointed to that role. It is different if I appoint someone as my attorney and they make that decision or, indeed, QCAT appoints someone as a guardian.

As I say, I started answering this question by saying that I have questions. I do not know how often that happens and I would be interested to know. It is not an easy question to answer, either. Whilst the Public Guardian can tell us statistics from her data, we will not know it in relation to private guardians and we will not know it in relation to attorneys and statutory health attorneys.

Dr ROWAN: If we were trying to bring transparency to what is actually happening there, would it be the Human Rights Commission? Who would be best to try to bring some transparency and have that aggregate data in a way to understand what is happening and where? Obviously there are remnants of different statutory office holders or different agencies. Where would it be best to try to bring that all together?

Dr Chesterman: That is a great question. I have wrestled with this for many years in different areas, even knowing how many enduring powers of attorney are out there. We do not actually know the answer to that question until we have a national register, which is on the books.

In this particular area, short of doing a broad population survey, which I am not recommending, the easiest way to do it would be to ask authorised mental health services how often consent for treatment is being provided to them by a substitute decision-maker. That would probably be the easiest way to get that information. The Human Rights Commission will not hold that information. In fact, no-one will hold that information. The authorised mental health services would be the best place to go to find out how often that is happening.

Dr MacMAHON: My question is also about the locking of acute public inpatient wards. Do you think the government's prospective implementation of OPCAT or the Inspector of Detention Services Bill will have a bearing on this policy and how it is enacted?

Dr Chesterman: The Inspector of Detention Services Bill will not because these facilities are not in their purview, but OPCAT certainly would in my view. I have been advocating for the implementation of OPCAT and the inclusion of various disability settings, including acute mental health facilities. Absolutely, it would. In fact, by being locked wards they would bring the situation of involuntary and voluntary patients in authorised mental health services within the purview of OPCAT.

Dr MacMAHON: I want to ask about your comments around the QPS referrals and not having a statewide mental health service provider any longer. I asked the commissioner about that this morning but there were not many details. Could you elaborate on that?

Dr Chesterman: I do not have many more details other than what was referred to this morning. In fact, we had a discussion about this earlier. It means that the police have to find a service in a way that in the past they did not. I am not here to say how well that system worked in the past, but it was an obvious referral step whereas now you have to find a particular service. That is the challenge. I do not have any more depth on that, unless you do, Tracey?

Ms Martell: No, I do not think so. I believe that the statewide service had a reduction in funding and, therefore, they were unable to take those referrals anymore.

Ms KING: I note in your submission you make a lot of recommendations and points regarding support people and better communication between treating teams and the person impacted. Do you have any commentary to offer about the potential role of lived experience peer workers in providing that more connected communication and that advocacy for people as they go through these processes?

Dr Chesterman: That is a great question. I think that is a key to having meaningful reform here. What I would be suggesting, which is not novel and I am sure others have suggested as well, is to consider the pathway that people with mental illness take through the service system, consider it as a pathway and then engage people with lived experience to talk about what helps at each step of the pathway, rather than from a service perspective of what service you are entitled to and how you can link that service. It is to think of the pathway and ask people with lived experience of mental illness what is most important at this particular stage of the journey.

Ms KING: Your comments—and correct me if I am wrong—seem to go to aspects of co-design. Although I think that is clearly exceptionally important, I am also wondering about the provision of support people to people with mental illness or forensic disability as they step through.

Dr Chesterman: It is a big challenge to identify how we enable people who do not have supporters around them to be provided with support. We know anecdotally that support can be provided to people, for instance, at Mental Health Review Tribunal hearings if they do not have someone there. That could even be a member of the treating staff, although that is obviously problematic from an independence point of view. There is some discussion about independent patient rights advisers being able to assist with approval in those settings.

It would be great to identify how we might have peer supporters encouraged to play that role where someone does not have anyone of their own choosing. That is an obvious place to go. You hear in other areas of the broad social services sector how meaningful that can be. We were hearing about it at a round table I convened on Friday in relation to people with acquired brain injury. It can be very meaningful for the patient who requires the support and it can actually be very meaningful for the supporter as well.

CHAIR: You talk about each agency engaging with the individual differently and the boundary being the doorway of the agency. We have had other submitters and people giving evidence who talked about the need for community based care coordination or care management. In your role, could you see some benefit in a system that follows the person rather than just delivering what that service delivers and then off they go?

Dr Chesterman: Absolutely. I have been fortunate over the past three or four weeks, with Tracey and another staff member, to have been travelling around conducting adult safeguarding round tables on this issue, not just in relation to mental ill health but also in disability broadly defined. The need for advocates and navigators is pronounced, because the service sector broadly defined—whether it is disability, mental health services or aged-care services—is increasingly complex. Increasingly you have private providers. Consumer choice underwrites this service sector, but that also means provider choice so providers can choose to provide a service or not provide a service. All of that requires navigation. Navigators are very important.

The obvious issue in the mental health space, too, is the relatively—for other jurisdictions—low level of community mental health services that exist and that are able to be coordinated. I make that obvious point as well. I absolutely agree that navigators are required and it is a reform area that is ripe.

CHAIR: Is that an issue that you run across frequently—that is, providers choosing not to provide a service?

Dr Chesterman: It is a skewed area. When we are conducting an adult safeguarding project, which is currently underway, we are focusing on situations where adults are at risk of harm in the general community. Obviously we are focusing on situations where there has been, for instance, service withdrawal. The fact that we do see that does not mean it is happening willy-nilly. We are focused on situations where it does. It is certainly happening frequently enough to be of concern.

CHAIR: I worked with an individual over the Christmas period who, as part of a condition of release from prison, needed to undergo a certain treatment in a certain facility but the facility refused so they were not able to get out of prison. We were able to find a solution eventually. I was not aware that it was something that was problematic until you mentioned it there.

Dr ROWAN: Dr Chesterman, I refer to those recommendations with the Mental Health Review Tribunal about some governance reforms and strengthening protections in some ways for consumers. There are two parts to my question. Via Queensland Health, does the Chief Psychiatrist or the Mental Health Alcohol and Other Drugs Branch have a particular view around those reforms? Have there been discussions there? If the reforms are to be implemented, do they need to be implemented from a legislative perspective or is it really just about how the tribunal operates?

Dr Chesterman: I think both elements would be in play. We have made a recommendation about audio recordings, obviously, and that is one thing. I guess clarity around who is able to support people at hearings and some kind of consistent policies there would be useful. This is from listening to people with lived experience, of course, who are seeking this. The other thing that people with lived experience of mental illness are seeking is, in terms of their participation at hearings, having more of a focus on recovery rather than on things that have happened in the past. That is an important way of establishing and gaining buy-in from patients to their own hearing process and their own future pathway. Does that answer the question?

Dr ROWAN: There were some very important recommendations in the submission. I am trying to understand the level of support across the system, so to speak—whether it is the Chief Psychiatrist, the Mental Health Alcohol and Other Drugs Branch, the Mental Health Commissioner. Obviously that is feedback that you have had through consumers, advocacy and other organisations. Would it need a legislative process to implement those or could it be done within the remit of how the tribunal, as a statutory entity, operates?

Dr Chesterman: I do not think that would require any legislative change. I know there are some operational hurdles that have been raised in relation to the recording of proceedings, although I think they can and should be surmounted. The other area is that I have, in fact, not heard anyone critiquing those ideas. In some ways they are pretty obvious ones that I would imagine most people would support.

Dr ROWAN: That is what I thought. I thought they were self-evident. Thank you very much.

CHAIR: There being no further questions, I thank you both for your presentation this afternoon. It is very useful for the committee going forward. We thank you for the work that you do. While your report will come out after our report, we will certainly be looking for it with great interest.

BROOKER, Dr Katie, Senior Researcher, Mater Intellectual Disability and Autism Service, Mater and the Queensland Centre for Intellectual and Developmental Disability

FRANKLIN, Dr Cathy, Director, Mater Intellectual Disability and Autism Service, Mater and the Queensland Centre for Intellectual and Developmental Disability (via videoconference)

CHAIR: We have been looking forward to your presentation. We will give you a few moments to make a brief opening statement and then we will go to some questions.

Dr Brooker: I am a researcher at the Queensland Centre for Intellectual and Developmental Disability, which we just call QCIDD for short, where Cathy is the director. My research has focused on health promotion for people with intellectual disability, access to primary care for autistic adults and more recently access to mainstream health services for people who have intellectual disability and autistic people.

Our aim at QCIDD is to support the health care of people with intellectual disability and those on the autism spectrum; however, QCIDD lost its recurrent funding due to clinical demands in this area a few years ago and now is a very small service. Previously, QCIDD produced quite a number of key resources in this field including CHAP, which is a comprehensive health assessment that led to the provision of a Medicare item for people with intellectual disability. More recently we developed ABLEx, which is a large online educational course about intellectual disability. Intellectual disability makes up about two per cent of the population and autistic people make up at least one per cent, so that is around 150,000 Queenslanders. Both of these groups have two to three times the rate of mental illness compared to the general population, so that comes to about 75,000 Queenslanders who experience mental illness who have an intellectual disability or autism. Intellectual disability and autism are also significantly over-represented in our prisons and forensic populations.

I am a researcher and I cannot help myself, so I am just going to quote some statistics for you. Queensland research has found that 82 per cent of the psychotropic medications prescribed to adolescents with intellectual disability were off-label and inappropriate. Autistic people have nine times the rate of suicide compared to non-autistic people, and we know from New South Wales data that people with intellectual disability are twice as likely to be readmitted after an initial admission for mental health.

I just want to note that the experiences of autistic adults in the mental health space are really under-researched and poorly understood, especially within the Australian context. People with intellectual disability and autistic people are expected to access mainstream services, yet research tells us that mainstream health services and mental health professionals lack the confidence and knowledge to work with this population. Queensland research with psychiatrists repeated through the 1990s, 2000s and more recently shows us that psychiatrists lack confidence in their ability to work with people with intellectual developmental disability, and quite a significant proportion would rather avoid working with this population if they could. These findings have not changed since the 1990s. The fact that a significant proportion of our psychiatrists would rather not work with this population points to the stigma and discrimination these people experience when they are trying to access mental health services. When people do manage to access services there are no suitable inpatient treatment facilities, so this group is incredibly vulnerable in our public mental health units.

People with intellectual disability and those on the autism spectrum have complex needs, and it is difficult to accommodate this type of need in a busy generalist setting. To complicate matters, when people with intellectual disability or on the autism spectrum are admitted, they have increased lengths of stay and indeed may be in hospital for very long periods of time, in part due to that lack of coordination between social services, the NDIS and Health.

People with intellectual disability tell us that they want their mental health professionals to be adaptable, to be able to communicate with them and to work with their support network. They also need their mental health professionals to build rapport and trust through demonstrating their experience and respect for working with people with intellectual disability. They also need their health professionals to understand trauma and how that influences their mental health needs.

My background is in health promotion and preventive health, so it would be remiss of me not to note there have been few efforts in the health promotion space in terms of accessible health information for people with intellectual disability and autistic people. When we look at the policy level, the needs of people with intellectual disability and autistic people are hardly ever considered; nor are they consulted or involved in policymaking, despite having a really significant health need.

Public Hearing—Inquiry into the opportunities to improve mental health outcomes for
Queenslanders

People with intellectual disability and autistic people experience systemic neglect in our health system. We really applaud the committee for seriously considering the experiences of people with intellectual disability and autistic people, as this group is often forgotten or thought of as someone else's problem. However, we do want to recognise that this is one of the many inquiries we have had in recent times and we are yet to see change. We would argue that we need resources and funding to make improvements in this area, and we really hope the committee can help us get to that point.

Dr Franklin: I am a psychiatrist and I specialise in the psychiatry of intellectual and developmental disabilities, including autism, in adolescents and adults. I am director of two small services: a clinical service called MIDAS, the Mater Intellectual Disability and Autism Service, and a research centre called QCIDD. I also present regularly at conferences on the topic. I have published papers, contributed to textbooks and teach psychiatry trainees. I serve on the RANZCP committee for the section of psychiatry in this area and I am vice-president of the Australian Association of Developmental Disability Medicine. Last but not least, I am also a third of the way through a PhD on the topic of researching how to increase capacity in intellectual and developmental disability mental health in mainstream mental health services.

I would like to highlight for the committee the current gaps in service for this population—or at least some of the gaps. One of the common ones is that, as children, people with intellectual or developmental disability, which includes autism, receive medical care from paediatricians. This works reasonably well except in complex mental health situations. However, as they enter late adolescence there is no equivalent to paediatricians in adult services, so people's care has to transition to their GP and occasionally to a private psychiatrist—if they can find and afford one—who is familiar with this area. This is the problem. This would be okay except for the lack of knowledge and awareness of this area by health professionals across the board.

Katie has already mentioned the previous research about GPs and psychiatrists in Queensland lacking confidence in this area and that many would prefer not to work with the cohort. Part of the reason is also that there is no backup. The only place in Queensland that a GP or private psychiatrist can refer for a specialised second opinion is our very small clinic. We regularly see very unwell people turned away from mental health services. Their GPs are struggling to help them and their mental illness goes undiagnosed and untreated, sometimes severe mental illness, for many years. Of course this makes it more likely that the person with intellectual or developmental disability will become homeless, commit offences and become long-stay patients in Queensland hospitals, not to mention the harmful effects on themselves and their families.

Further, I have also seen the effects of lack of capacity within Queensland Health's mental health services. In 2019 the Mental Health Alcohol and Other Drugs Branch at Queensland Health commissioned MIDAS to undertake an 18-month project to assist Queensland mental health services with clients with intellectual or developmental disability. We saw patients who had been stuck in hospital for months—even years—and we also saw people who, despite having severe disability, were having difficulty accessing NDIS. Of course, that was often very crucial in helping them to get out of hospital. Over the 18 months we saw 135 complex patients. We had NDIS plan data on about half of that group, so about 60. The total NDIS funding for that complex group increased from \$3.5 million for those 60 people in total to \$7.5 million after our project. The project only cost \$1.2 million to run for 18 months.

I know that our clinic has been mentioned so I might just quickly answer a bit about that. Our usual clinic is an outpatient clinical service that takes referrals from all over Queensland, but we lack funding to travel so we conduct telehealth outside of the south-east corner of Queensland. I do have patients in Innisfail, Rockhampton, Monto and various parts of the state who telehealth and come to the clinic when they can. There is also a specialised intellectual disability mental health service that is located within Queensland Health mental health services that services those people who are current patients of the mental health service, but it does not see people who have autism with no intellectual disability.

MIDAS receives about 450 to 500 referrals a year. Our wait time is currently around 10 to 12 months. Our recurrent funding is \$800,000 a year from Queensland Health mental health branch. This provides for one full-time psychiatrist position, one nurse, a GP one day a week, one admin officer and a part-time project manager. We also have a psychiatry registrar through the federally funded Specialist Training Program.

A major part of the challenge is that health professionals lack knowledge and confidence. There are even more gaps in the area of autism, where there is no available education for health professionals at this point in time. There are also a lot of negative attitudes and stigma against people with intellectual or developmental disability. This can manifest with individuals being denied entry into Brisbane

mental health services but also systemically where clinicians and policymakers believe that people with intellectual or developmental disability do not belong on their mental health service. Today I am here to call on the inquiry to make a finding that Queensland Health mental health services lack capacity in this area and require additional resourcing to improve access to services for people with intellectual disabilities or autism. I am happy to take questions.

CHAIR: The submission from James Morton—I am not sure if you are familiar with it—made a number of recommendations, primarily around establishing a centre that sounds a lot like your centre but better resourced with more research, outreach and training components. Could you comment on that particular recommendation and whether that is where you would see this service being improved if we were going to do something?

Dr Franklin: I think it is important to acknowledge that the gaps are widespread, so there is unlikely to be one single thing that would help. Having said that, the model of a centre of excellence or a centre that works to improve health through education, clinical service and research is one that has worked well to date. It is very under-resourced. I think the important things in Queensland's current situation are that all parts of the healthcare system need somewhere they can really ask for a second opinion. I think people with intellectual disability and autism suffer needlessly because they cannot access this. I think that would be one important role of a centre like that. I think it would also be very important that a very clear mandate would be that it would not just be about clinical services; it would need to also have a clear remit to increase capacity in the area through education but also through offering training positions for medical staff, including nursing and allied health.

CHAIR: I have worked with people with intellectual disabilities in the past. I am a registered nurse. I have seen the treatment of people with intellectual disabilities in acute care services, not mental health services, and I have noticed a difference in the way nurses and other health professionals interact with them. We have a system of Indigenous liaison officers throughout the state who do a good job in terms of assisting nurses and other health professionals to deliver culturally appropriate care which leads to better outcomes for patients. Is there room for some sort of a similar role for providing on-the-ground support to support healthcare professionals to understand and develop better care plans and care practices for people with intellectual disabilities and autism?

Dr Franklin: Absolutely there is. As far as I am aware, at least in some of the hospital and health services in Queensland there are disability liaison officers. This type of position has been trialled at various stages over the years. One of the difficulties with it previously has been the lack of support for those positions and the number of positions. At the moment, it is really a lot of administrative work and trying to contact people rather than working directly with patients about accessing services. It is something that has certainly been trialled. I am not sure how many there are within the mental health service currently. It is certainly something in the general hospitals that exists in at least some of the HHSs.

Dr ROWAN: Thank you, Dr Franklin and Dr Brooker, for your very detailed submission. I want to build on the questioning from the member for Greenslopes and what you, Dr Franklin, mentioned about the centre of excellence around clinical service, education and research, and I guess building capacity and increasing and upskilling our health workforce. I am happy for this to be taken on notice. I refer to additional resourcing infrastructure with respect particularly to beds and the need that is actually out there to service the current number of patients or clients who fall into this category. I want to get a sense of what that would be, particularly with respect to clinical service provision seeing as there is already some amazing work being done through MIDAS and the Queensland Centre for Intellectual and Developmental Disability. As the member for Greenslopes indicated, that really builds on the back of some of the testimony Associate Professor James Morton presented to the committee. Is there any idea about inpatient bed numbers, what could be serviced and what is needed to fulfil that clinical service aspect?

Dr Franklin: I probably would have to take that on advisement because, off the top of my head, that would be difficult. One of the important things to understand would be what part of the population you are hoping to serve. The mental health service does have an intellectual disability mental health service already. The general hospital services do not and the community has our small service. We are about one-third of the size of the mental health service team. I think it is important to have sufficient scale to be able to do enough work. It would also depend on whether there would be inpatient beds as part of that or if it is continuing with a similar sort of the model that we have currently, really. That probably is going to make the financial difference in the budgeting, I think.

Dr ROWAN: If are you happy to take any of that on notice and if there is any additional information, that would be very helpful for the committee.

Mrs McMAHON: Thank you for your submission. Reading through your submission, particularly some of the data on the vulnerability of people with intellectual disability and autism, is quite frightening as a parent. I was wondering if you could talk to me a little bit more about the diagnostic overshadowing and its prevalence in the public mental health system. What does that actually mean in terms of outcomes for that vulnerable cohort?

Dr Franklin: Diagnostic overshadowing is a big term. The easiest way is to give an example, really. That is when someone with an intellectual disability or autism turns up to see a health professional and the health professional does not see their mental illness or their physical illness. They just say, 'Look, go home. It's just your autism. We don't do that here.' I would like to say that that does not happen now but it does happen a lot currently. We see it frequently. You might wonder why that it is.

There is, I think, a multitude of reasons for why that happens. It feeds into the fact that this is not just about a lack of knowledge; it is also about discrimination and stigma that people with intellectual and developmental disability face. However, having also been a psychiatrist and a registrar and a trainee working in the public mental health services—they are stretched, they are not equipped to work with people with intellectual or developmental disability and inpatient units are often not safe places for this population—I can also see why this happens but, at the end of the day, it is very damaging to a person to have untreated illness in this day and age. I do not know if I have answered the question properly.

Mrs McMAHON: You have explained what it is. I guess it goes back to that first GP level involvement as well. As I said, if you are a parent the first port of call for your child is the GP. Because autism can manifest itself in so many different ways, it would be quite hard for the standard GP in a very short consult period to work through a lot of the ASD issues and actually get to an underlying mental health issue. How much training or exposure to this cohort do our GPs need in order to be better prepared to assist them in a standard GP role?

Dr Franklin: I might go against the grain slightly here, but I think a lot of these concepts are quite fundamental concepts. It actually may not take a whole lot of education because health professionals know a lot already. All they need to know is that it is easy to mistake the features of autism and intellectual disability for physical and mental illness. If they knew that and could understand that, that would help them immensely. If they had someone or somewhere that they could refer to for a second opinion or further help, I think that would also help.

We are actually developing some education currently in an NDIS funded project that we are hoping will become mandatory education for hospital and health service staff. We have been working with a disability theatre company to develop videos to try to help health professionals understand this concept. There is just no exposure in undergraduate education. People are not familiar even with how to talk to someone with an intellectual disability or autism so it is probably of no surprise that these things happen further down the track.

I think it is not complex. I do not think they need years of extra training but we need representation. Intellectual disability and autism do not feature in a lot of policies and they really need to. The problems that we have currently relate to a lack of representation in undergraduate training and postgraduate training.

Mr MOLHOEK: In your submission you talk about the issue of polypharmacy and off-label prescriptions and the fact that in Queensland there are about 80,000 people with intellectual or developmental disabilities. How common would that practice be? We have heard issues discussed earlier today around physical and chemical restraints. Should we be concerned that a large proportion of people have been subdued chemically and have not really been looked after properly?

Dr Franklin: This is an issue that was raised initially in the Carter report in 2006 and resulted in a raft of reforms to services. That is how all of the restricted practice legislation came around. The difficulty is that in real life, with a lack of capacity and health professionals in the sector, prescribing still becomes the most straightforward thing to do in these sorts of situations, but it does not need to be now. To be honest, the NDIS provides resources for behaviour management and a lot of input from a variety of allied health professionals. It is an ongoing problem. It was also raised in the Office of the Public Advocate's report. Katie might need to correct me on the name of the report. There was a report recently looking at the deaths of people in care who have intellectual disability.

It is still a problem and it still needs addressing. People end up dying through oversedation. The real difficulty is that this population—people with intellectual disability and autistic people—do not really get a choice to be noncompliant with medication. They keep taking it and when something goes wrong the dose goes up. That is a substantial difference to a lot of the general population who,

by one way or another, often become noncompliant. I know I have trouble finishing a course of antibiotics, but I would not have a choice about that if I lacked capacity; I would be finishing the antibiotics. People collect more and more medications as time goes on.

Mr MOLHOEK: I would hazard a guess that it is perhaps a common practice among people outside of your scope of focus in terms of intellectual and developmentally disabled people. I would guess that there are other people who have been prescribed or overprescribed medications just to try to manage them rather than help them work through the issues and provide them with a pathway.

Dr Franklin: Queensland has a very robust, I think, way of detecting and monitoring chemical restraint now. The weak link, from my perspective, is really the lack of medical expertise in reviewing the medications and knowing what to do about that from there.

Mr MOLHOEK: Would there be much illicit drug use in this space as well to deal with some of these issues?

Dr Franklin: There certainly is, particularly in people who have mild intellectual disability and who are having difficulty. They are very vulnerable. This is the group that we see over-represented in the prisons and also often well known to the Office of the Public Guardian.

Ms KING: Throughout the course of this inquiry, on a number of occasions we have heard evidence from other submitters about their recommendation that the child and youth mental health system should extend up to the age of 25. Several of them have described young people aged 18 or so who are transitioning between the child and youth mental health services to adult mental health services as 'falling off a cliff'. Do you have any commentary around that in relation to people with intellectual disability and young people who have autism, and whether that would be of assistance to the group that you are advocating for?

Dr Franklin: In practice, people with intellectual disability and autistic people are often not followed up by child and youth mental health services for a long period. They tend to be much more commonly followed up by child development services, so Child Health. That seems to be how the system works in Australia. Certainly transition is an enormous problem but the transition that we see is far more commonly from paediatric services rather than child and youth mental health.

CHAIR: The Mater has a youth health service that tries to deal with that issue. I know they have specialist youth physicians. If that service were more widely rolled out across the state, would it deal with the issue that you raised around paediatric care not transitioning into the teenage or young adult years?

Dr Franklin: In relation to people with intellectual or developmental disability, the word 'transition' always makes me a little bit twitchy because there are such wonderful things said about it. The difficulty in our services is that there is really nothing to transition to, or not much. The longer someone can stay in paediatric services probably the better. However, the difficulty with this group is that they generally have ongoing needs into adulthood, really. It might be different in some other groups, but this group has an ongoing level of need.

Transition is certainly difficult, but the main problem tends to be a lack of anywhere to transition to. If we had better resources, some of the things we would look at in that space would be trying to help people engage more with their general practitioners when they are in paediatric services, because they tend to be very well managed by paediatric services but have not met their GP much until they turn 18 and then suddenly the GP is in charge. Looking at building up primary care and people engaging with their GP earlier I think would be helpful. Some of those things are the things that the Mater Young Adult Health Centre looks at.

CHAIR: I imagine it is not just the mental health issues; it is the physical health. From a lot of what I have seen, particularly in the community sector, there are no active attempts to alter people's diet, exercise, smoking or other behaviours simply because they have an intellectual disability so we just let them go. That seems to be what you are describing in the mental health space as well. It is just a sense that, 'Oh well, they've an intellectual disability and we don't have to worry about that person anymore.'

Dr ROWAN: I want to come back again to the notion of that centre of excellence group for such a service in relation to clinical service provision, education, training and research for people with intellectual and developmental disability and/or mental health comorbidity. Are there any other state jurisdictions that have a similar model that you are aware of that are able to achieve those outcomes and not only providing inpatient admissions but also being an outreach statewide service? Is there anything that exists, whether it be in New South Wales, Victoria, Western Australia or other places, that you are able to point to—or even internationally, for that matter?

Public Hearing—Inquiry into the opportunities to improve mental health outcomes for
Queenslanders

Dr Franklin: New South Wales has made significant investment in the area. They have established a number of intellectual disability health services. They also have established an intellectual disability statewide mental health service. It has only just recently commenced, though. It builds on the fact that there are existing intellectual disability health services. I think there are about four to six—Katie might know better than I do. There is that model in New South Wales. Victoria has some different models. They have a child and adolescent and an adult version of a similar sort of service based out of a hospital with not a statewide but a more defined catchment area. There are a number of different varieties, mostly through Victoria and New South Wales, that have significantly higher levels of service and investment in the area, particularly in New South Wales in recent times.

CHAIR: Thank you very much for the work you do and for your submission and presentation here today. It has been very useful for the committee. There was one question taken on notice. We would appreciate the response to that by the close of business on 26 April. Thank you very much for appearing today.

Dr Franklin: Thank you very much.

**EMMERSON, Professor Brett AM, Chair, Queensland Branch Committee, Royal
Australian and New Zealand College of Psychiatrists**

CHAIR: Welcome. Professor Emmerson, I invite you to make an opening statement and we will then go to the committee for questions.

Prof. Emmerson: From the college's point of view, we have been pushing for an inquiry into mental health services in Queensland for about 18 months. We welcome this inquiry. The main reason we welcome it is that most mental health inquiries in Queensland have been specific. There has been the 10B inquiry or the closure of the Barrett centre and they have also been looking at negative things that go wrong in our system. To my knowledge—and I have been around mental health services for 40 years—this is the first inquiry where we have actually had external people come in to have a look. We welcome this greatly.

The issues facing Queensland mental health services at the moment, before we get onto my long list of solutions, relate to a number of interactive factors. The first is that our mental health services—we are talking here the Queensland public sector—have been underfunded for 10 years or more. We have the lowest per capita funding of any state. This leads very much to the fact that our public mental health services have the lowest staffing levels. Unlike other parts of the health service where staffing makes up 75 per cent of the budget, the budget for staffing mental health services is 90 per cent. We do not have artificial limbs and all the flash equipment that the rest of the health service staff do. We are very dependent on our staff and, by having the lowest staffing levels, our staff then have probably amongst the highest case loads. The higher your case load, the less efficient you can be.

The other factors that have played into the current predicament for our Queensland mental health services relate to the fact that Queensland Health has had about a 62 per cent increase in their funding over the last 10 years. Mental health services has had about 10 per cent. We are not seeing the growth that the rest of the health service system has seen, which is a pity. The other thing that has coincided with this issue is the fact that there is a workforce crisis. We do not have enough staff. We cannot recruit. Part of the issue for that is: the last time Queensland had a mental health plan was between 2007 and 2011. If you do not know what your growth funding is going to be on a reliable basis, it is really difficult to plan your workforce.

The final thing that has really, I think, made life very difficult for the Queensland mental health service as we speak is COVID. COVID has led to vast changes in the way services have been delivered. It has led to vast increases in a number of areas of presentations to emergency departments. That sets the stage as to what we, the College of Psychiatrists, would like to see as a solution.

The first thing, as I said earlier, is that we need a five-year mental health plan. It would be great to see it as bipartisan. The worst thing is if mental health services are run by one party and the opposition feels they have to block it. As I say, it is great to see a bipartisan committee. The other thing that the college was pleased about is that we have eight out of 76 parliamentarians who will know a lot more about mental health and hopefully you will all be around for a good time to follow through with what needs to happen. We would like a bipartisan approach.

If you look at what the mental health system needs, it is funding. The AMA is calling for between \$600 million and \$700 million; we are calling for about \$750 million; and I think John Allan got up and said that he thought, based on the National Mental Health Service Planning Framework, it would be about \$900 million. If you look at all the other inquiries that Australia has had—the Victorian one, the New Zealand one, the productivity one—significant funding has followed, and if you pro rata the Victorian investment, that is where I get my \$750 million from. Now, we could not spend \$750 million now; we are talking about \$750 million in five years time, and you probably need to grow funding, if you can, by about \$100 million to \$120 million a year over those five years.

Where do the changes need to happen? They need to happen in our community mental health services. The community mental health services in Queensland are still, in the main, psychiatric outpatient clinics. They work Monday to Friday. There is skeleton staff at weekends and in the evenings, but we really need to move into the 21st century where we have staff available for at least two shifts, seven days a week. We are calling for 3,000 additional mental health staff when we hit the \$750 million per year, which I am sure you are going to give us. The National Mental Health Service Planning Framework, which I know you have had a presentation from Professor Whiteford on, calls for about 2,000. We are actually calling for 3,000 because the 2,000 generally is Monday to Friday dollars and, if you start adding in penalty rates, Saturdays are time and a half and Sunday is double time. If you look at evenings, you will need 3,000 FTEs to get us up to where we need to be.

Public Hearing—Inquiry into the opportunities to improve mental health outcomes for
Queenslanders

The other area in Queensland where we are woefully lacking is in the non-government sector. We have about 25 per cent of the staff that we need to follow people up. If you have schizophrenia and you get admitted to hospital in Queensland, you will probably stay about two weeks. You will then be discharged, and if you are lucky enough to get an NGO package you will get good follow-up. If not, you will be visited by your case worker from the mental health service probably in the first week, you might get a phone call in the second week and then they will see you fortnightly or something like that, but a lot can go on in that time.

I do not know if you are aware, but if you get a chance, get Richmond Fellowship to present their Hospital to Home program to you. This started at Prince Charles Hospital when I was at Metro North. It provides follow-up. Each unit has about one discharge a day, and there are five discharges, so we only see about 20 per cent. Under this program, someone who is discharged will receive three home visits a week from usually a peer worker, and it just wraps up what is going on. They have someone who can take them shopping, look into their banking issues, if they need hairdressing or whatever—this group supports it. Consumers love other consumers. We will talk about peer workers in a minute, but I think they are grossly underrated because they do a really good job. Those are the needs of the NGO sector.

The other area, while we are talking community, is the drug and alcohol sector. Mental health services are the poor cousins of health. Alcohol and drug services are the very poor cousins of mental health. We have tragically low funding. A lot of funding seems to end up in the NGO sector. The NGO sector can do a lot, but we have not seen any growth in the state based alcohol and drug services. As part of whatever is hopefully allocated out of your inquiry, a lot has to be directed to the drug and alcohol sector—particularly the state sector, not just the NGO sector.

The other thing, as well as community mental health, is beds. Queensland has about 1,500 beds and there is a range of those beds. The National Mental Health Service Planning Framework talks about another 500 beds needed. I will run over the types of beds we need in a minute. We also need 250 refurbished beds. When I was in Metro North, there were seven acute adult wards. Only one of those was built this century; the other six units are all built last century. If you get admitted at Royal Brisbane, you can end up in a four-bedroom bay with a single toilet. It is just not contemporary and it just does not enable you to provide contemporary mental health care. People focus very much on new things, but we really do need to refurbish a lot of our current bed stock.

What beds do we need? We need acute beds, especially psychogeriatric beds. We actually need some long-stay psychogeriatric beds because currently there are a range of people who end up stuck in acute psychogeriatric beds that nursing homes will not take. They end up in the acute beds. We need some state funded, long-stay psychogeriatric beds.

In terms of step-up step-down, if you have not been to see one you should go and have a look at one. There is a good one at Nundah House. These are usually run with NGOs. They are good with peer workers and they are certainly an ideal alternative to acute hospital beds if the risks are appropriate.

We need mother-baby beds. There are four mother-baby beds in the whole of Queensland. You need usually about 10 mother-baby beds per million population, so we need at least 30 of those. We used to pop mothers with babies in our acute units. Those units are just not appropriate anymore with the level of risky patients. There are five specified eating disorder beds in the state. That needs to be increased. Certainly we need more adolescent beds, particularly in Central Queensland.

The other area that is just beginning but is looking very promising is the crisis stabilisation units. There is a new crisis stabilisation unit at the Gold Coast. It is adjoining the emergency department at Robina. All reports are that it is looking very promising and it is an ideal way of diverting people away from busy emergency departments, yet they are still close enough that if there are medical or security problems they can be rescued. The college believes that we probably need about 10 or 11 of these units across Queensland, mainly in some of the bigger centres. That is certainly another area of need.

There are mixed feelings in the health sector about this next area, but Queensland is one of few jurisdictions that actually admits serving prisoners to our acute adult mental health wards. The really risky ones go to high-secure, but there are not enough high-secure beds. We are calling for the development of a 25-bed medium-secure unit, probably at The Park, that can take not only high-risk, complex patients direct from the adult units but also the prisoners. One of the issues I have noticed over many years is that every time you have a serving prisoner—they are called classified patients—in an inpatient unit, the families and the voluntary patients do not like that level of association. It is also one of the things that contributes to our wards being locked all the time. I think if there was a

25-bed ward initially in South-East Queensland, it would free up more acute beds for voluntary patients and patients under the Mental Health Act, but it would also, I think, lower the level of risk that we are asking our acute inpatient facilities to carry.

The next area is quite topical. Cathy Franklin was just here. We are also calling for a separate mental health and wellbeing service for people with intellectual disability. Under the Queensland Mental Health Act, people can be found on a forensic order (disability). There is a 10-bed unit at The Park, but if you need any other follow-up outside of that, those services are provided by adult mental health services. If some of these people have a treatable mental health diagnosis that is fine, but where they just have a pure intellectual disability they do not mix well with people with chronic mental illness. If you have not heard, there are regularly people with just pure intellectual disability admitted to our acute units, and they just do not fit in there. The milieu and the culture do not support them so they inevitably get frustrated, they will play up, there is violence and they are then secluded.

We have people with purely intellectual handicaps staying in mental health wards for years. NDIS has made some improvement, but it is not still perfect. The college is not talking about providing any services to these people; we are talking about trying to have a specialised service. Instead of Cathy's unit coming out to educate already overstretched adult mental health on how to manage a very different group of patients, we are suggesting that we probably need to develop a proper mental health and wellbeing intellectual disability service for the state.

There are other areas where we think there need to be major changes in the workforce area. As I hinted at earlier, we cannot grow the workforce if we do not know what funding we have coming on. The only time we had that guarantee was between 2007 and 2011. In that time we actually knew each year what the growth funding was going to be and we were able to do targeted overseas recruitment and interstate recruitment, but in the main we got on to the universities. The universities are very keen to work with health departments to grow the number of mental health nurses, OTs, psychologists and social workers.

The other area that I think Health has to look at is: at the moment we probably need to expand the number of disciplines, so people like health physiologists who can look after your physical exercise programs. We need a whole range. Mental health pharmacists are becoming increasingly vital to what we do. Probably the most vital group—it is strange that I leave them until last, but I mentioned them earlier—is peer workers. Peer mental health workers can perform a role that I cannot. You will see peer workers sit down with people who are agitated and they are able to tell them, 'I was like you three or four years ago. This is what I've done, this is what I've achieved and these are strategies you might consider.' The peer workforce is very underfunded and undervalued. The college is calling for significant growth in the number of peer support workers.

Moving away from the workforce to systems governance, the role of the Queensland Mental Health Commission when it was established was fairly narrow, but we think the commission should have a broadened role. If there is a new mental health strategy, the commission needs to have increased jurisdiction to monitor, advise and evaluate any new mental health strategy as it rolls out. The beauty of the commission is that it is across government. If it just sits within Queensland Health it is very difficult for one department to monitor and report on another. Queensland has an excellent Mental Health Commissioner and we think the role of the commission should be broadened if there are going to be changes.

The final area—and this fits in with the Productivity Commission's findings—is that we probably do need to set up regional mental health planning committees. Some of the PHNs and health services have mental health plans already but, as you are probably aware, the PHNs are getting increased mental health funding from the Commonwealth over the next five years. I think it is going to be very important—almost vital—that the public mental health services, the NGOs and the PHN services work together, because I think partnerships are what mental health is all about. That is all I have to say at the moment.

CHAIR: I am sure we all enjoyed the part where you said you want us all to stick around for many years! I think most of the committee already have that on their next corflute. If we just accept that we need more of everything, from emergency rooms onwards—that big, long list that you gave us—there has been strong evidence already provided around the need for alternative approaches to managing crisis care and there are pockets of things happening already. I want to come back to starting principles, where you finished off, and that is the planning process. The Productivity Commission talked about the need for regional planning. You refer to regional mental health planning committees. Who would you anticipate would have input or a role in those committees?

Prof. Emerson: I think it is probably too early. Victoria have just set up their regional committees. I think they appointed five chairs. They have very clearly demarcated who is going to be on those boards or committees—whatever they are—and their roles, so I think we could probably learn from Victoria. Whether we are NGOs, PHNs or public sector mental health services, it is vital that we get in there together. We have to draw in areas like housing and employment agencies. That all goes without saying. In answer to your question, I do not know who chairs them or who funds them, but a number of the PHNs have very sophisticated mental health staff. From my days in Metro North working with the Brisbane North PHN, I can say that they are an excellent body and they work well with public sector mental health services.

CHAIR: The committee has heard much about the issue that is created by the gap between GP services—the initial diagnosis—and what is for many people the first time they actually get serious care, which is usually when they are in crisis. You have referred to the need to strengthen the community mental health and NGO sectors. Is that where you see us responding to that gap between GP services and the emergency department and trying to provide more services to stop people progressing to the need for hospital care?

Prof. Emerson: I think if we had more community mental health staff and more NGOs you would have less. Currently, mental health services work on the fact that if you have a defined service and you cannot expand too much then you are going to be dealing with crises and a whole range of other people just do not get a look-in. It is not unfair to say that GPs are very busy and mental health patients take longer than the five minutes that most GPs allocate, so the Commonwealth remuneration for GPs does not encourage GPs to take on mental health patients. If you can get a good GP who will bulk-bill they are excellent, but there are not enough of them.

CHAIR: There is always talk about more funding at that early intervention stage, but we have also had some of your professional colleagues advocate for early psychosis services. There has been a lot of evidence proffered around the growth of eating disorders and the need for early intervention there. Do we need to roll out more services for those people who are having early experiences of schizophrenia, eating disorders and those sorts of things—better treatment options, more of them, more widespread?

Prof. Emerson: The answer is yes. If you can get to people, whether they are in early psychosis, early stages of an eating disorder or whatever, you are less likely to see them go down a chronic course. In the early psychosis area, treatment early on has been shown to reduce chronic morbidity and patients becoming chronic further down the track, so the answer to your question is yes. With eating disorders, if you can get them early, or earlier, the chance of them moving into chronic patterns of behaviour that will affect them for the rest of their lives is reduced.

CHAIR: It was refreshing to hear you talk about the need for attention being paid to physical health as well. It seems to me—I worked in Rosemount in the 1980s—that it is an area that has often been quite neglected for people with mental health issues.

Prof. Emerson: If you have a chronic mental illness in Queensland you will have the same disease profile as our Indigenous population. You will die probably in your fifties. If you have schizophrenia, you will probably smoke. Half of them do. Out of that you will develop chronic airways disease. A number of the new antipsychotic medications we give people are very effective but they cause massive weight gain and metabolic syndrome, so you will probably be obese. You will probably have diabetes. Because you have chronic schizophrenia, you will ignore your health. You will probably end up living in substandard accommodation. Some of the boarding houses are terrible. The food that you are fed in a lot of these places is suboptimal. Usually there is nothing to do, so you will sit around all day smoking. You will have three meals of food that is not ideal for people with those sorts of conditions. The state has a group called the Mental Health Clinical Collaborative, which has done a lot of work to try and identify that people with severe mental illness need their physical health monitored. That is going along quite well, as is the smoking stuff, but actually getting the patients and mental health staff to intervene as assertively as I would like is still a challenge.

CHAIR: No-one likes telling them, 'You're not to do this.' I might go to the deputy chair for a question or two.

Mr MOLHOEK: Thanks, Professor Emerson, for joining us today. In one of the earlier hearings we heard some commentary from one of your colleagues or one of your members around the public health system compared to the private health system or the non-public health system. The comment was made that the public health system has become so risk-averse that most trained psychologists and psychiatrists working within Queensland Health are spending up to 80 per cent of their time processing paperwork and dealing with red tape because there are so many risks with people with significant mental health issues and they are just not getting to see that many people face

to face. The comparison was made that outside of the system a typical psychologist might see eight people a day and spend 20 per cent of their time on paperwork but in the public health system they would be likely to see two a day. It was not so much a reflection on the attitude or the performance of the personnel but rather a comment around the ridiculous burden that we put on practitioners in terms of paperwork and risk management.

Prof. Emmerson: I will make a couple of comments. The health information systems that we have in mental health come from the 1990s and are similar to the current community based one. You then have hospital based either charts or electronic medical records. The two systems do not talk to each other. If you want to enter a drug allergy in the community one it does not necessarily show up in the hospital one, so you have to actually do double entry if you want things to be done. The number of requirements from the corporate system about what they want and what they expect to be documented does take—I am not sure if it is 80 per cent but I would say 60 or 70 per cent. The answer is yes, the mental health system is made inefficient by the requirements for documentation.

One of the advantages of the private system over the public system is that the public system is so overwhelmed in terms of numbers that it is very difficult to get continuity of care. It is illness based or episode based, so you will get your care for three, six or 12 months unless you have a really severe illness. You will then be sent back to a GP or a private psychiatrist. One of the big positives of private psychology and private psychiatrists is the fact that they provide continuity of care. The relationship between you and your patient is vital.

Again, the Commonwealth made what I would suggest was an unwise decision about 18 months ago due to COVID. All of a sudden they doubled the number of Medicare sessions from 10 to 20. That sounds great—20 sessions—but they have not doubled the number of psychologists. In effect, they have halved access. In my view, you are better off getting 10 sessions rather than half the people getting 20 and the other half not getting any. Access is a significant issue in both public and private. That has also happened with COVID.

Mr MOLHOEK: It is an interesting comment you raise around the doubling of sessions. There is a submitter whose name escapes me but who will be appearing during one of the later hearings. I was talking with one of their practitioners who said it is often not the number of appointments but the quality of the appointment. They suggested that if a proper pre-therapy analysis is done, the right questions are asked and there is a clear understanding of the patient's needs—if that is done well then sometimes many patients require only two or three sessions to deal with their mental health issues and they go away equipped and happy.

Prof. Emmerson: I would agree with your comment.

Mr MOLHOEK: What could we do to improve our systems and our approach to mental health in that respect?

Prof. Emmerson: You are right: not everyone needs 20 sessions or gets 20 sessions. I think generally people respond, and it is usually self-evident if someone has reached a point where they no longer need to come. It is not so much what you are describing. It is about the number of people available in both the public sector and the private sector. There are not enough practitioners to see everybody who warrants a service, whether that is three sessions, 10 sessions or 20 sessions.

Mr MOLHOEK: Earlier today we heard from the Australian Counselling Association. They were suggesting that we could address that by making more counsellors available. I raised some questions around how well equipped counsellors are versus psychologists. It would be interesting to hear comment on that.

Prof. Emmerson: I am not aware of the training of counsellors. I know it is a three-year university course. We have had meetings with the Australian Counselling Association ourselves. For people with mild to moderate issues, counsellors may well be a cost-effective way of supporting people. I think you need to have an efficient triage system in place to be able to say, 'This person's level of service fits with this skill set.'

Mrs McMAHON: Your submission specifically looks at a recommendation for the government to explore a consultation liaison model. You indicate there are various different models out there. I am interested in what this model looks like in terms of the patient experience. There are a lot of mental health professionals involved in this. What basic tenets of a model do we need to make sure that the patient experience throughout this is front and centre of whatever model is adopted? At what point is the GP involved? At what point is a psychologist, a psychiatrist, a counsellor or a mental health nurse involved? They are all in there. For a person's first intervention in that mental health space, what does that model look like?

Prof. Emmerson: Consultation liaison services have traditionally been provided to hospitals from mental health services. If you get admitted to Princess Alexandra Hospital because you have taken an overdose or you have chest pain but you are also feeling depressed, you will be admitted to a medical ward and the consultation liaison services will be provided by the mental health service into those wards. They will come and see the person. Most consultation liaison services in the big hospitals have psychiatrists, senior mental health nurses, psychiatric registrars and psychologists. It would depend on the presentation or the triaging as to who sees you. From that triage, a decision will be made as to what part of the system you should be referred to or, if you are staying in hospital for a number of weeks, who will see you and what treatments you need. That is where the term 'consultation liaison' comes from.

It has also been used, however, to try to support general practitioners and other groups. A lot of GPs see a lot of mental health patients. Twenty per cent of general practice is mental health. It may be even more depending on the diagnosis. Sometimes GPs do not have the confidence to take on or make some of the decisions. The idea of actually being able to contact people to either see the person for a one-off appointment or to phone them has been well and truly considered and that has been in practice for many years. It works very well, particularly in rural areas. Some of the rural GPs, say, around Emerald are very good at giving a good assessment, providing feedback over telehealth and then coming up with a joint management plan. It is certainly a cost-effective way of providing services.

Mrs McMAHON: When we were talking about EDs—and, as you said, it is a crisis point when someone's first point of contact is with an ED—you made reference to the mental health crisis stabilisation unit at Robina. Are there similar units throughout major hospitals, or is that the first one that you are aware of?

Prof. Emmerson: That is the first one in Queensland. Again, my knowledge and what I have heard about Robina is that it is a model that is probably worthwhile carrying through with. One of the reasons mental health services in Queensland have reverted to emergency departments is that up until about 15 years ago Queensland had—and they still do—things called acute care teams. They were community based teams whose job it was to prevent people getting to the emergency department. They were designed to assess people and manage them in the community wherever possible.

What has happened with the four-hour emergency department rule and of course no funding is that the hospitals are now saying, 'We have mental health patients in the emergency department. You need to move some of your community based staff back into the hospital.' That is what has happened, but all of a sudden we do not have acute care teams of sufficient size or experience to manage people in the community. If you phone a number of mental health services, particularly at night, the acute care team will tell you, 'Come up to the emergency department. We will see you there.' That is not the role they were set up to perform. Again, that is partly a function of not having sufficient resources.

Mrs McMAHON: On that crisis stabilisation unit, I know at the Logan Hospital we have the Mental Health Lounge, which is attached to the ED as an alternative place to wait for triage. I am wondering whether a stabilisation unit attached to the hospital, as opposed to a particular model which is not attached to the hospital, that potentially still has clinical staff and is also very peer workforce led but in a non-hospital location is another option in terms of an authorised mental health service but one that is not such an intensive drain on resources.

Prof. Emmerson: They have set something up in Adelaide which you have probably heard of. I take it that is what you are referring to. I forget the name of it. It seems to be working. I think psychiatrists are a little concerned that if you have units away from emergency departments, if something goes wrong it is sometimes really difficult for police, ambulance and other mental health workers to know what is really going on. If you go to one of these new peer-led services that is not near an emergency department, if something were to go wrong it is difficult to get people out safely. Certainly from the College of Psychiatrists' point of view, the Robina model whereby you are on a hospital campus, you are separate but you can get access to emergency department staff quickly if you need it would probably be the preferred model.

Dr ROWAN: Thank you to you and the Royal Australian and New Zealand College of Psychiatrists for the very detailed submission. If I look at the recommendations for reform—for the Mental Health Commission to oversee the allocation of state funding for mental health services; to monitor, advise on and evaluate mental health reforms; regional mental health planning committees; the five-year mental health plan to look at infrastructure, workforce, models of care and community non-government organisations—a lot of that is around what I would term whole-of-government system reforms at that very strategic level and moving across other agencies, whether it is Health, Brisbane

Education, Corrective Services or other agencies. Has there been any thought given to whether there should be a standalone cabinet minister to drive some of those system reforms with the Mental Health Commission having a secretariat function, for want of a better term, to assist with the implementation? I do not mean an assistant minister role within Health; I mean an actual standalone cabinet minister who has the authority and the power to negotiate some of these significant funding elements which obviously have to occur with Treasury. When we look at the quantum of money that is being proposed to be injected into the system as well as the beds required and the additional units, whether it is in intellectual and disability services or in relation to a new classified patients unit, how at that high strategic, system level do you drive some of those changes and governance reforms throughout the system?

Prof. Emmerson: The college does not have a position on a mental health minister. That is the first point. The second point is that the College for Emergency Medicine had a seminar in Melbourne about three or four years ago, and a number of us were drawn down for it. Stephen Duckett was there. He had done an analysis of those states that had a mental health minister against those that did not. Those that had a mental health minister seemed to do worse than those that did not have one.

I think it comes down to the seniority of that minister. If you are going to have one, it probably needs to be the Premier or the Deputy Premier. I think in Victoria it is the Deputy Premier. In Tasmania the fellow who has just become Premier is continuing with mental health. Having a junior minister as the mental health minister that allows them to tick the box to say, 'We have a mental health minister,' is probably not going to be effective. If you are going to have a mental health minister then they need to be somebody with significant clout who can absolutely get the agenda moving and keep it moving.

Dr ROWAN: That would be the Premier with a portfolio of responsibility for that, or the Deputy Premier?

Prof. Emmerson: Or the Deputy Premier, yes.

Dr ROWAN: I want to ask about the statewide specialist inpatient unit for Queenslanders with mental health, intellectual and developmental disabilities. From your opening statement that is not only about providing optimal evidence based care, but there is obviously a human rights aspect, particularly with respect to the seclusion elements you talked about earlier and the extended lengths of stay in adult mental health units. Having that standalone unit is to provide—

Prof. Emmerson: It is not just the standalone inpatient unit; they will need some acute beds, but they are going to need community based teams. Those community based teams would certainly work in parallel with the community mental health services, but they do need to be separate because I think it is a separate skill set.

Dr ROWAN: So it would be an inpatient unit but a statewide service?

Prof. Emmerson: As I say, I do not think it necessarily has to be run from Health. I think it should stay with the department of disability or whatever it is now known as.

Ms PUGH: My question is around alcohol and substance abuse, which you touched on earlier. According to the National Alcohol Strategy, one in four Australians drinks to risky amounts and the risk of having a mental illness is four times higher for risky drinkers than for those who are not risky drinkers. Those two numbers combined is a substantial part of the Queensland population. Obviously alcohol, unlike other substances, is widely condoned for misuse in the community. What can we do to better educate the community that completely abstaining from alcohol is quite a socially acceptable choice and, if not, drinking to non-risky amounts is the way to go? Secondly, how many of those Queenslanders who are drinking to risky amounts are we seeing coming through our mental healthcare system and how can we better address that specific cohort?

Prof. Emmerson: In terms of public awareness, if you look at what Australia has achieved with smoking you find that as a country we have gone from smoking rates of 60 per cent or 50 per cent down to about 12 per cent, and we are dropping by about one per cent. If you want to look at what needs to happen, the way they have gone about tobacco control et cetera is something that could be looked at. Bear in mind that the one group that still smokes too much is people with chronic mental illness. Some 50 per cent of people with schizophrenia smoke to that.

Coming to the second part of your question, which I think relates to what we do with people who have problematic drinking and how we see them, we see them in emergency departments. Royal Brisbane started something called DABIT, the Drug and Alcohol Brief Intervention Team. I think there are about six or seven DABITs across the state. Those programs are well worth the money that we paid for them. We probably should have DABITs in every emergency department. They get people at a time when they are hurting or unwell. They have fallen down and have hurt themselves and it is not

a bad time to sit down, take a history and say, ‘Your alcohol seems to be impacting on you quite distinctly at the moment. Have you thought about—’, and then trying to funnel them into an NGO for an alcohol and drug program. That is one area. The other area is the people drink-driving and having education rather than punishment for some of the drink-driving or at least making that a mandatory part of their rehabilitation. They would be some of the areas.

Finally, the other area that you talk about is that there are people who have major depression and schizophrenia who drink. Most mental health services have a dual-diagnosis mental health professional. People can be plugged in for an assessment and referral to appropriate agencies.

Ms CAMM: Professor Emmerson, I thoroughly enjoyed reading your submission. It makes a lot of sense. My question is about the workforce. You point to the need to grow the workforce. We travelled to the Wide Bay area for this inquiry. I am from the Central Queensland region. It is no surprise that across north and regional Queensland there is a significant shortage in specialists—and not just psychiatrists; we struggle to get many different specialists into the regions. What do you see as the alternative models of delivery or capacity building to bridge some of the gaps that we see right now? Secondly, does the college have a view on how we further grow our own psychiatry professionals rather than look at international recruitment, which is currently not succeeding? After speaking to HHSs I know that they are going out three or four times with recruitment rounds and competing against each other for the same skill set. What is the college’s view on that?

Prof. Emmerson: That is actually worse since COVID because we have not been able to bring people from overseas or interstate.

Ms CAMM: It is also about retaining people in the regions, which is exceptionally challenging in the majority of specialities.

Prof. Emmerson: The long-term answer to your question is what is going on in the Wide Bay and Central Queensland now, where you are starting to have a medical school. I am sure you are aware of that. I think the first students have started in Rocky already.

Ms CAMM: JCU is similar in North Queensland.

Prof. Emmerson: Yes, you are from that area. That is going to be the answer in the long term. One of the problems for psychiatry—and I have done a bit of rural relieving over time—is the fact that when you are in even large centres like Cairns people know a lot about you. As a health professional, it is much easier to hide in Brisbane. When I was in Cairns everybody knew where my wife shopped. If you have dinner somewhere, people know you. Sometimes as a psychiatrist you have to make decisions that people do not particularly like. Trying to remain protected is a challenge. That is something that I do not know how to get around. The only thing is growing your own and getting —

Ms CAMM: That is an important point that you make. I have never considered that. I think that is an important point that you make.

Prof. Emmerson: About 30 years ago in Queensland Health we had a husband and wife team and one other psychiatrist go into Rockhampton. We said, ‘Tick. Critical mass. We have three of them.’ The husband and wife were on call two out of three nights. They lasted 18 months to two years. That on-call work and then being expected to get up at seven o’clock in morning to go and give ECT or whatever the requirement is makes it incredibly difficult.

The big hospitals like Royal Brisbane, Prince Charles and PA have an on-call roster of one night a month or something like that. Even in some of the larger centres you are on call one or two nights a week. Some places have rules whereby anybody who is going to be discharged who has been suicidal has to be discussed with a consultant so you are rung at three o’clock in the morning. There is a whole range of things that discourage that.

I have always favoured linking the big centres with some of the smaller centres and making service at some of the smaller centres the incentive to get a job at the bigger centres. In theory that works but, as you say, everywhere is so short that people will just look after themselves. If they leave Rockhampton to go and take up a job at the PA then Rockhampton is disadvantaged. It is a complex area.

I think telehealth makes a lot of sense for psychiatry. You can do good work along that consultation liaison model that you spoke of. With telehealth you can see the person’s face. It is pretty real. Telehealth works well for a number of mood disorders and anxiety disorders. It did not work quite so well last year for some of the eating disorders because you cannot see the weight loss. It can be a challenge. It is not good for everybody.

Ms KING: Thank you, Professor Emmerson, for your submission; it is incredibly detailed and very interesting. I have a couple of questions. Firstly, I might ask about your suggestion and the suggestion we have heard from other submitters around enhanced investment in the alcohol and Brisbane

other drug space. Everybody, pretty much, who has addressed the issue has said that we need more investment in alcohol and drug services. I would really like to hear from you whether you have any views about what specific types of investment in that space are most needed.

Prof. Emmerson: It is across the whole area. Alcohol is still a major issue, but you still have the opiates and a whole range of other substances that are problematic. In the last three or four years there have been a number of government grants going to the non-government sector. The non-government sector do a good job so I am not saying that they should not get the funds. I am not aware of any growth funds that have flowed to the government alcohol and drug services that usually end up with the severe cases that the NGOs cannot manage. When you ask what area it should go to, I think it has to go to all areas.

The other area that the Mental Health Commission has been talking about is the move towards decriminalising. I am sure you have all heard about the Portuguese dissuasion commission. We are not talking here about dealers; we are talking about individuals. It is about having something along the lines of that model whereby individuals who are clearly dependent are funnelled into the health treatment area rather than into the criminal justice area.

Ms KING: That would of course lead to a great increase in presentations in our health services once more.

Prof. Emmerson: That is not resourced.

Ms KING: On an only tangentially related theme, I suppose, you have provided incredibly detailed representations regarding where you think further investment should go by the Queensland government into our mental health system as a whole, and I thank you for that. I note your favourable comments about the work of PHNs and also the comments in your submission about some of the pressures on GPs. If you were making an equivalent submission to the federal government, what would you be recommending to ensure that, as Shaun Drummond said to us, all boats rise equally to avoid his concerns about a displaced demand—that is, if you lift one part of the system very quickly you will get all of the demand flowing into that part of the system? What would you recommend to the federal government were you submitting to them?

Prof. Emmerson: The PHN budgets are small. When I left Metro North, Metro North Mental Health had a budget of about \$220 million a year. We had about 1,500 staff. The PHN had a mental health budget of \$20 million. The problem for the PHNs is the fact that most of their line items come with, 'You are to run this service or a headspace.' There are four or five headspaces which they are not allowed to fiddle with. Pat McGorry is politically brilliant and he has been able to get the federal government online. Where I am leading is the fact that the PHNs are told where most of their money has to go so there is no discretionary funding. A lot of what came out in the federal budget last week or the week before will go to the PHNs, but it is all line items. For example, the Head to Health clinics—there will be five of those. There will be Way Back Support Services here and there.

Again, the PHNs have no budget. We sat down with our PHN three years ago, I think it was, and produced our first national regional mental health plan in Metro North. Again, there was no money. The state money is tied. The federal government money is tied. There is no discretion to be able to say, 'We want to put money into this particular area or that particular area.' In answer to your question, I think the Commonwealth needs to start giving funds to the PHNs that do not come with, 'You will provide this service.'

Dr ROWAN: In relation to the question by the member for Pumicestone around alcohol and other drugs, would the alcohol and other drug workforce unit, which was mentioned on pages 27 to 38, be within the Mental Health Alcohol and Other Drugs Branch and, secondly, would that be responsible for a funded and dedicated number of addiction medicine or addiction psychiatry specialist registrar training positions like they have in New South Wales?

Prof. Emmerson: The reason we put that in is that we actually need a central mental health workforce unit. We used to have one until 2011. Then it disappeared. It is that unit. We are trying to say that we need to re-establish a mental health workforce unit, of which there needs to be an alcohol and drug section. Again, we cannot let continue what has happened previously, whereby mental health gets the crumbs and the drug and alcohol services get one crumb. It is really to focus on the fact that a central workforce unit is needed and there has to be a significant component of that for the alcohol and drug services.

Dr MacMAHON: Your submission recommends an additional 3,000 community mental health staff be employed. We are looking at innovative models. Do you have a breakdown of what particular expertise should be included in those 3,000 and any particular models from here or other parts of the world?

Prof. Emmerson: I think the models that Queensland has in place now with having acute care teams, continuing care teams, mobile intensive treatment teams, first-episode psychosis teams, step-up step-downs—most of the components are there; there are just not enough of them. I think the areas where we need particular enhancement are at that front end. Our acute care teams that have been diverted into emergency department teams need major enhancements. Most acute care teams finish at nine o'clock at night. They need to go 24 hours a day. We need to go back to being able to visit people in the community.

The one area where we are reasonably starting to restart is hospital in the home. There are a lot of people who can be treated assertively in their home. If the person is not at high risk to themselves and they have a supportive carer, you can send staff out. We started at Royal Brisbane about three or four years ago—a small, home based acute care service whereby we have two staff, two shifts a day, and a psychiatrist and they can manage about six or seven people with depression. The staff will go out and see them every day. The psychiatrist will go out and see them twice a week. That is very effective. It saves hospital beds. The patients like it. If that does not work, you can then steer into the step-up step-down facilities rather than going to the acute inpatient units. When you ask where they should all go, they need to go across the spectrum.

The other teams that do absolutely brilliant work—I do not know whether you have contacted them or had a presentation from them—are the Homeless Health Outreach Teams, the HHOT teams. They are spectacular in the work that they do. The one at Royal Brisbane will be up with the food vans at 6.30 in the morning just down the road there in the parks. I do not know whether you know it, but you can live free, if you like—sausages at the Homeless Health Outreach Team. These teams follow people up. They are out under the bridges; they are out well into the evenings, following up people. They will use iPads to beam people in to follow them up.

I think our whole community area is understaffed and that is why we rely so much on our hospital beds. If you had a proper functioning community—and within that community I think comes the crisis stabilisation hubs as well—we would have a much better system. If you have people with reasonable case loads then the support of GPs and the support of the private area becomes much more doable.

Dr MacMAHON: Following on from your comments about the homeless outreach teams, which would seem to me to fit into a prevention category, what else in the prevention space, before people are hitting hospitals and even before they are seeing any kind of mental health issues, should we be funding?

Prof. Emmerson: I will make a couple of comments. One is the fact that child and youth mental health services are the place to start. I think a lot of mental health conditions come in in your late teens or early 20s, so having adequate services in that area that are adequately staffed and able to take people on would be the closest we would come to in terms of—it is probably secondary prevention, but there is not a lot of primary prevention. Parenting classes will help people understand how to be parents.

The other area which you have brought up which I think is a danger for mental health services is that traditionally the public sector mental health services have been for people with severe mental illness—schizophrenia, major depression, bipolar disorder, severe personality disorders, people who are suicidal et cetera. There is this new term coming in called 'wellbeing'. Victoria has jumped on the wellbeing bandwagon. I kind of know what wellbeing is, but, equally, saying that that is mental health's responsibility is wrong, I think. The wellbeing is across government. Wellbeing is a reasonable roof over your head, it is three meals a day and it is getting an income. The best thing you can do for a lot of our people is give them a part-time job. Wellbeing is much broader than us. I hope that your inquiry does not go down the track of realising that—there is mental health, but then there is wellbeing and, as I say, we have not got the mental health and alcohol and drug space right yet. Trying to say that we are suddenly responsible for wellbeing could dilute and direct resources away from where I think it is needed.

Mrs McMAHON: Directing you to the comments in your submission in relation to your workforce issues, I note that you recommend a five- to seven-year workforce plan which would obviously sit alongside a five- to seven-year mental health plan. Noting the issues that it takes to grow your own workforce locally, whether that is at the undergraduate program, the postgraduate, the supervision or specialist training, and also your comments about the international medical graduates, where do you see the best potential for increasing that workforce in the short term—say, the one to three years versus the three to five? Where can we get best bang for our buck in growing that workforce in the short term? Assuming we get all those additional beds that you request, without the workforce it is quite useless.

Prof. Emmerson: Exactly.

Mrs McMAHON: In terms of growing this workforce, what do we target now to then grow that workforce over the three-, four-, five-, six- or seven-year workforce model?

Prof. Emmerson: If we use nursing as an example, I think the nursing workforce is there. Mental health has to take a lot more responsibility in ensuring that mental health is part of the curriculum. If you look at medical training and nursing training—and they are the two that I am most au fait with—one of the areas that the College of Psychiatrists has been pushing for, for medical staff, is to have a mandatory mental health or psychiatry term in your first or second year. We have failed. We have written to medical boards for years. When 20 per cent of general practice and 20 per cent of most practice is going to have mental health, to graduate and go into private practice after two years without having any mental health experience, apart from a term in third year, is wrong. Again, in most of the nursing courses now you probably will get a three-week term. Certainly in the early 2000s, there were a couple of courses organised in Victoria whereby you could do a Bachelor of Nursing but you would have a whole range of mental health nursing subjects so you would actually graduate as a mental health nurse. I think those are some of the areas that we need to look at.

Equally, some of the services in Metro North have taken on offering nursing students part-time positions within the mental health service, so they will come in as an assistant nurse, they will work two or three days a week, weekends and that sort of thing, and if they like mental health nursing then when they graduate they come back. Metro North took about 48 first-year nurses this year. Broadening the experience and also mandating that you cannot graduate as a nurse or a doctor without experience both in your undergraduate and in your postgraduate experience might be a way.

Mrs McMAHON: Who pulls the levers for that to happen? Is that done through boards? Obviously the universities are the ones that need to deliver.

Prof. Emmerson: If government were to say to people like chief health officers, 'We want mandatory psychiatry terms for medical graduates,' I am sure they would listen. Equally, if we have a workforce unit out of a five- or seven-year strategy, they can start to negotiate with the nursing courses.

Mrs McMAHON: Can you comment on how well Queensland is placed in terms of being competitive in attracting international medical graduates? COVID aside, how well as an employer is Queensland Health in its ability to attract international medical graduates in the field?

Prof. Emmerson: I think it is reasonably good.

Mrs McMAHON: What kinds of numbers would you envisage needing to attract in the next, say, three years to help fill that space that we are missing?

Prof. Emmerson: We will need some. The area you have to be very careful with—I think there are 27 psychiatrists or a small number in South Africa—is that you do not want to be recruiting from countries that are actually going to disadvantage the local population. Certainly Australia seems to get a lot of very good Indian graduates. In India there is no shortage, so we are not diminishing the access of the Indian population to psychiatry. There are some countries and there are certainly some cultures—I think the Indian group are highly influential and they are usually trained in English, and English skills are very important for psychiatry.

CHAIR: You mentioned mental health pharmacists. Before we have another war between the pharmacists and the GPs, I want to find out a bit more about that. Is that like a community pharmacy role with a bit of a specialisation in mental health and being able to manage that polypharmacy issue, or is it more a hospital based role?

Prof. Emmerson: I think it is a community based one. I am not sure it is a role that the community pharmacists can do, but they can be trained to do it. There is great benefit in having somebody from a pharmacy point of view sit down and go through medications. Some of our patients, particularly the psychogeriatric ones, will be on 15 or 20 medications and the risk with a lot of these is that people will start something new but they will not cease the previous one. Senior mental health pharmacists know about drug reactions which I have long since forgotten about. I have found in the last few years that having somebody with specialist knowledge to actually meet with the patient, review files, go through their medications and rationalise it is highly cost effective and beneficial.

Mr MOLHOEK: In your report you talk about the issue of housing and you talk a lot about beds, too. I would like to hear your view in terms of whether we have enough supported housing in Queensland. Probably more importantly, what models of supported or crisis housing have you seen or are aware of from other parts of the world that you would consider to be best practice and a model that perhaps Queensland Housing and the government should be looking at?

Prof. Emmerson: The answer is that we do not have enough housing. That is very clear. Brisbane still has probably about 1,000 boarding house beds. If you want to go and have a look at one, you should. They are not ideal places. They are slightly better than homelessness, but not much. You asked what models work. Harvey Whiteford, who presented to you earlier on the mental health workforce, used to say that you need three things, that mental health is a three-legged stool: a treatment arm, accommodation and a job. We need a lot more accommodation.

I think the groups that do the best with housing are the NGOs and there are a number of very good ones. The Brisbane Housing Company and those sorts of agencies will build them. They develop good links. I think the Brisbane Housing Company has good links with the homeless team. Those are the sorts of models I would promulgate. I do not know about models from overseas. I do not have much experience in terms of overseas housing.

Mr MOLHOEK: One of the concerns I have heard raised around models like, say, Common Ground and the Brisbane Housing Company is that you are, in a sense, clustering a group of people with common issues—although not all the same—with supports, which is a good thing. I have had people say to me, ‘You’re just rebuilding the old institutions of the fifties and sixties.’ Do you have a view around that?

Prof. Emmerson: They are not the old institutions because they are generally in clusters of 15 or 20. Of the big psychiatric hospitals, Wolston Park in its day had 3,000 and I think Baillie Henderson had 1,500. We are not going back to those days. I think it is inevitable but how do you develop supports? It is not ideal putting everybody with a mental illness together and I think there needs to be matching. Again, just in terms of the ability to support people, by having groups that might have four or six homes in a particular area you can get staff who can support those groups. I think smaller groups are the way to go.

Mr MOLHOEK: In the child safety system we have created residential care homes, in my opinion, really as a bandaid to try to find places for kids we cannot place in foster care and who we do not feel should be with their families. There have been a lot of issues around that with kids going through multiple placements and so on. Again, are you aware of any other models of care for those sorts of groups?

Prof. Emmerson: I am not aware of any other models. I am an adult psychiatrist dealing with psychosis so I should not go into the child and adolescent area because I just do not have knowledge, I am afraid.

Mr MOLHOEK: Fair enough, thank you.

Dr ROWAN: Professor Emmerson, with the implementation of the new Mental Health Act in 2016, have there been any unintended consequences with respect to inpatient capacity in public mental health units? What I mean by that is, given the changes to classified patients or patients on forensic orders, have there been implications for those public mental health units?

Prof. Emmerson: Not really. The act clarified and I think it is a much better act. I forget what they were called now—I think they might have been called ‘restricted patients’, but I am not sure. The model has not changed but it is certainly my view that putting serving prisoners in general adult inpatients is not ideal.

Dr ROWAN: In Metro North there is a hospital alcohol and drug detoxification unit of 20 beds. Do you have any comments about the need for that, whether it is on the south side of the river in Metro South or other parts of Queensland?

Prof. Emmerson: I think having one 20-bed detox unit for the state does not work. Certainly if you look at the HADS, the Hospital Alcohol and Drug Service, a lot come from Metro South. It serves the metropolitan area well. You will get some people from the Sunshine Coast and the Gold Coast, but you very rarely get anyone from outside. To have a couple more detox units I think would be ideal as well. Putting people into acute adult mental health facilities for that, again, is not ideal.

Dr ROWAN: Finally, on managing physical comorbidity for people with mental health disorders, as you outlined before there is reduced life expectancy with diabetes, metabolic syndrome and other things. Should there be consideration in the public system to having specialised clinics to manage that physical comorbidity for mental health patients?

Prof. Emmerson: The answer is yes. That is why I spoke earlier about getting exercise physiologists, physios, dieticians and so on. That is why we need to expand from the traditional five mental health professions, which is psychiatry, nursing, OT, psychology and social work.

Dr ROWAN: And they would be managed as dedicated clinics with those sorts of groups—
Brisbane

Prof. Emmerson: Again, they can have a consultation liaison role. They do not actually have to see people but actually have a presence. It is like having Indigenous mental health workers or dual-diagnosis workers. It is actually having people on hand that you can talk to in a break: 'Look, I've got somebody with this issue. What do you think?' You cannot carry all your knowledge around with you so actually having access to colleagues who know is very useful. I think some services are now putting on exercise physiologists and trying to address it actively.

CHAIR: Professor Emmerson, if we somehow came back to you with a bucket of money, how do we stop this situation that has occurred where it seems like the HHS funding has increased but the mental health portion of that has, at best, stagnated?

Prof. Emmerson: I think the people who make the decision about who gets the money are not from mental health. The idea that Queensland Health has grown by 62 per cent and mental health by 10 per cent—those are decisions made by non-mental health people. Hopefully out of this inquiry will come a recognition that mental health is an area of great need, it has been underfunded and we need to direct money in those directions. That is one of the reasons I was suggesting we need a body external to Queensland Health, like the Mental Health Commission, to actually track the money and see that it is spent on the reason for which it has been allocated.

CHAIR: The other question I have relates to the NDIS. Other submitters, particularly psychiatrists, have raised some concerns around the NDIS and the inability of people to utilise the NDIS to pursue active therapeutic recovery treatments. Other submitters have said that, actually, you can pursue non-medical treatments that in some cases might be more appropriate. Do you have a view on how the NDIS is working in terms of mental health?

Prof. Emmerson: I am not across the NDIS as much as some of the other areas. I would say that those people who have ended up with sizeable packages are much better off because of the NDIS. I think the NDIS, in the psychosocial space, has been very beneficial for those people who can get packages. One of the issues with the NDIS is that it is about how you write your submission. Traditionally, doctors do not write in the terms that the NDIS requires. You almost need specialised knowledge to help you with your application.

CHAIR: How does the My Aged Care system go in terms of supporting people around mental health needs?

Prof. Emmerson: I have no knowledge of that.

Mrs McMAHON: Turning back to the workforce, we have spoken about the peer workforce. We have had some submissions from bodies within the sector that look to this committee to make some recommendations around targets for a mental health workforce that is a peer workforce. Do you see that as a suitable recommendation? What are some of the potential issues around workers who identify as peer workers or those who specifically take up peer roles, and their training and qualifications in the mental health space?

Prof. Emmerson: The number needs to go up. When I was in Metro North we had an FTE of about 1,300 and we had probably about 12 FTE peer workers. We probably had about 30 peer workers, because a lot of the positions are part-time. That was not enough to even have one on each community team so I think the number has to go up. There are a variety of opinions about how many peer workers you need. There is certainly an issue in Victoria, as I understand it, whereby the lived experience workforce is growing at the same rate as the clinical workforce. I am not a supporter of that. I would think in Metro North we probably need about 50 or 60 FTE, depending on how broad and what we expect them to do.

Mrs McMAHON: Do you think it should be set along targets within a percentage of a workforce or a cohort within a workforce?

Prof. Emmerson: I have no knowledge of that. I am not aware that anywhere has a formula. As I said, Victoria seems to be working on 50 clinicians and 50 peer workers. I think that balance is not right, but I cannot tell you what is.

Dr MacMAHON: Your submission calls for an immediate funding increase of \$88 million to bring Queensland mental health spending up to the national average and then ongoing funding of \$750 million per year. Can you elaborate on how Queensland sits in relation to other states and other similar jurisdictions? What would you anticipate to happen if funding does not get up to those levels?

Prof. Emmerson: As I have said previously, we have had the lowest of all states over the past 10 years. Victoria has just had their royal commission and they have pumped in \$3.8 billion, and the uplift there is going to be about \$1 billion. We need a significant increase but it needs to be steady. If you came to us and gave us \$750 million now, we could not spend it; there is just not the staff out
Brisbane

Public Hearing—Inquiry into the opportunities to improve mental health outcomes for
Queenslanders

there. We are talking about that \$750 million in five years time, because without the ability to have a central workforce unit and grow and train our own we are just not going to get there. Does that answer your question?

Dr MacMAHON: The other question was what you anticipate if we do not get those levels of funding.

Prof. Emmerson: If we do not get those levels of funding, we will continue to have mental health services that are overstretched and we will continue to have people in the population who are not getting the treatment they need. No treatment generally leads to chronicity, which then makes the whole situation much worse and the interactions of people who are untreated are creating the next generation of people who will need treatment. It is short term, in my view.

Dr ROWAN: To follow on from the question of the member for South Brisbane, does that factor in COVID-19? I know it is a bit hard to predict, but can you give us commentary on what we have already seen in the last two years and that tail? The Queensland Mental Health Commissioner said that they were expecting over the next few years that there will be an additional burden from COVID-19 and other aspects. We have certainly seen eating disorders and other issues. Obviously, there is a catch-up that needs an injection of funding, which you have outlined. In relation to COVID-19, are there any other concerns or aspects that need to be considered as part of the planning?

Prof. Emmerson: I think all we can say is that COVID has created a mental health issue in the community that will go on for the next five years. I would probably swing the question around the other way to say: if we do not get the funding that we need, we will continue to have Queenslanders who are not getting adequate mental health treatment. As I say, that figure of \$750 million is a pro rata of the \$950 million that Victoria is putting into their services.

CHAIR: Professor Emmerson, I thank you for a very long session on your own this afternoon but an extremely useful session for the committee. We do appreciate the very positive approach you have brought to the work of the committee. No questions were taken on notice.

Prof. Emmerson: Can I raise one question with you?

CHAIR: Sure.

Prof. Emmerson: Before I came in you were mentioning about the new age group for younger people, from 13 to 25. One of the concerns I have as an adult psychiatrist is that when we start expanding that age group up to 25 we are starting to not provide services for people in the 13 to 15 age group. You almost need to have two age groups. Say you have an inpatient unit for people aged up to 25. If you are 13 or 14, you are not going to do well in a group with people aged 23 or 24. We have to be very careful with recommending that range.

CHAIR: I will ask you to take a question on notice. You caught me just before we closed. The Mater hospital has a youth health service; it is not mental health. It is a youth service that looks at both physical and mental health aspects. They have youth physicians.

Prof. Emmerson: Yes, they do.

CHAIR: They are specialist physicians in that age group. It would be interesting for you to look at that and give us an opinion from the college's perspective in relation to that. Certainly something that many submitters have talked about is how to group that age group.

Prof. Emmerson: I think for physical health what they are doing is fine. The issue is if you have a group of men aged 23 to 25 compared to some immature 13- and 14-year-olds. They are not going to mix on the one ward in a mental health sense. That is my concern. It is not the physical health that I am worried about.

CHAIR: I thank you for making that contribution. You have now taken one question on notice. Could we have the answer back by 26 April? You almost got out of here without homework. I thank everybody who participated today. I thank our Hansard reporters and our hardworking secretariat staff for all their help today. A transcript of today's hearing will be available on the committee's webpage in due course. I declare this public hearing closed.

The committee adjourned at 4.31 pm.