# *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)
Mr BL O'Rourke MP (virtual)
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

**WEDNESDAY, 13 APRIL 2022**

**Brisbane**

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**The committee met at 9.33 am.**

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

I would like to introduce the members of the committee. I am Joe Kelly, the member for Greenslopes and chair of the committee. Mr Rob Molhoek, the member for Southport and deputy chair, is joining us via Zoom. Also with us are Ms Ali King, the member for Pumicestone; Mrs Melissa McMahon, the member for Macalister; Mr Barry O'Rourke, the member for Rockhampton, who is joining us via teleconference; Ms Amanda Camm, the member for Whitsunday, who will be joining us soon; 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.

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## Ms ECKERT, Ms Christine, Member, Board of Directors and Director, Research and Development, Grace Homestead (via videoconference)

## Ms KNORRE, Ms Zoe, Founder and Chief Executive Officer, Grace Homestead (via videoconference)

**Ms Knorre:** Is Christine Eckert online?

**CHAIR:** Not yet.

**Ms Knorre:** I will read her statement. Christine says—

> Academic research confirms that mental health, substance use disorders and domestic and family violence are interconnected in complex ways and must be addressed holistically to improve intergenerational wellbeing. Each issue exacerbates the other and in combination become inherent barriers to effective treatment, causing increasing trauma, stigma and marginalisation for vulnerable women. Operational solutions must address the structural issues of funding, discrepancies between treatment and child protection practices, lack of appropriate treatment programs and the needs of parenting women who have had their children removed. Grace Homestead proposes that the parent-child model of trauma informed treatment creates ongoing generational benefits and promotes human rights.

I will tell you a bit about Grace Homestead. We ran from 2018 to 2022 in a small-scale pilot study. We had a 69 to 72 per cent success rate. We measured success by a woman who was no longer abusing substances and had her children in her care six months post treatment. About 88 per cent of our graduates were in work or study six months post treatment. The program looks at all of the social determinants of treatment. We cannot just address substance use; we need to address the reasons they cannot get a job and the reason they abused substances in the first place. We know that when we remove children from their mother's care we create more trauma. The Grace Homestead program was created to address those complex and multiple factors.

**CHAIR:** How long would the people referred to your service typically stay for a residential term? Is there an average length of stay?

**Ms Knorre:** The average length of stay was 262 days.

**CHAIR:** It is quite a lengthy program.

**Ms Knorre:** Yes, it is. We know that years of trauma and years of substance abuse cannot be managed within six weeks or a 10-week program. We know that it needs to be a long-term intervention.

**CHAIR:** Do you have an age range for the children? Is there an upper limit? Are there any restrictions?

**Ms Knorre:** We had an age range, and that was partly due to our local council. We took children from birth up to 10 years of age. That worked out really quite well, because then you were excluding those issues that you come across in adolescence. That is not to say that future programs cannot take children older than 10, but it just worked nicely for our program.

**CHAIR:** It is interesting that the council had an issue with kids over the age of 10.

**Ms Knorre:** I guess going through the process of opening a rehabilitation centre comes with its own issues. There were boundaries put around what we could do in the area that we opened.

**CHAIR:** In terms of the service, have you faced much stigma from the local community where you operate?

**Ms Knorre:** When we went to public notification we did, but we took the time to go and sit with the community. We would go and sit with people for a couple of hours at a time, and by the time we left they got it and they knew that what we were doing was a good thing and they were offering their help. Once you take the fear and ignorance out of it then people are able to see, 'This is a good thing. There are drugs in my neighbourhood anyway. This is the one place where there are not going to be drugs in my neighbourhood,' and it worked out well.

**CHAIR:** You have a fairly lengthy period of time with people—almost a year—so your program works through things like housing, employment, budgeting and a whole range of other parenting skills as well, I imagine.

**Ms Knorre:** Yes. We run a couple of parenting programs. We ran the Circle of Security program, teaching parents about attachment, bonding with their children, and then the really simple PPP basic parenting skills program. Parents will come to us with absolutely no idea of how to connect with their child, no idea how to keep their house clean or keep their house safe, and we were able to show them those skills. Not only within therapy but also because we were a 24-hour centre, the support workers could follow through. When a parent is having a meltdown at dinnertime—she has two kids who are both crying and dinner is on the stove—that is where the rubber meets the road. That is where they need the support to put their new skills into practice.

**CHAIR:** I feel like I need therapy just being reminded of those situations. I want to ask a final question before I go to the deputy chair. Are there therapeutic interventions aimed at kids as well or partners who may be not living there but involved?

**Ms Knorre:** We did not do any work with the partners. We ran a domestic violence program with the women which taught them about their human rights and boundaries and assertiveness skills. We attempted to link partners in with external services. For our children, some of them needed one-on-one therapy and they received that. Some of them just needed a behaviour management plan which was trauma focused, and we were able to manage any behaviours that way. We found that, for the children who have come into a safe environment that is calm, when they know what their routine is and they can see mum starting to stabilise, that is often enough for them to start to settle.

**CHAIR:** I would just like to acknowledge that Christine Eckert, member of the board of directors and director of research and development, has joined us as well. Please feel free to jump in on any questions that you like, Christine.

**Mr MOLHOEK:** Thanks for agreeing to appear today. I had the privilege of meeting with you—certainly I think Zoe and some of your colleagues—maybe two years ago now. I am just wondering if you can expand on the program. As I understand it, it is intended to be fairly holistic. One of its aims is to keep families together, which has a spin-off benefit—that is, we are not returning children to the child protection system but we are actually protecting them in place with their mothers and keeping them safe from harm in terms of domestic violence perpetrators or other family members who have been difficult. I would just like to hear a bit more about the holistic idea of the program.

**Ms Knorre:** When we opened in 2018 we were the only centre in Queensland that took a mother who had a substance use disorder and her child. At that point there had been another centre but it closed I think a couple of years prior. At that time the only option that a mother or a parent had was to relinquish their child to get residential treatment. We opened in 2018. We got a lot of referrals from Child Safety and a few through mental health as well. Often we would go and pick the mother up from detox and then we would go to the foster-care home and pick the child up from foster care and then bring them both back to Grace Homestead together.

In terms of treatment, the mother receives four days of group therapy per week. We are based on evidence based gold standard for mental health, domestic violence and substance use treatment. The children go off to day care or to school while their mother receives treatment. They then come back home and we encourage them to play and to connect with their child. The mothers also receive individual psychological care. We have what we call a ‘kids connect’ program, which is based on the Circle of Security concepts.

What we know from the past few decades is that removing children from their parents to intervene is not working. We know that mothers are too scared to reach out for help because they do not want their child to be removed. We know that mothers with substance use disorders often cannot get a bed in a domestic violence shelter. If women are in a domestic violence relationship often they are excluded if they have an active substance use disorder, so they are stuck in that dangerous relationship.

What we are doing is addressing all of those different factors in one centre and we are doing that in a holistic way. We are doing it an evidence based way and we are collecting data to make sure that what we are doing is working.

**Mr MOLHOEK:** Have you had the opportunity to do any analysis around—I hate to put it in commercial terms—the cost-benefit to the public health system, the child protection system and the plethora of other services that get involved? When you look at the proposal and the numbers it looks like a lot of money, but from what I understand the model that you have been running has been quite cost effective.

**Ms Knorre:** I will let Christine speak to that, but first I would say that we spend $5.8 billion per year on child protection. That does not even take into account mental health and domestic violence. We can run this program for so much less than what is being spent at the moment.

**Ms Eckert:** Just to go back one step, when we talk about family reunification, Australian based researchers Fernandez and Lee have evidence that shows that parents with substance use disorders have an 86 per cent lower rate of reunification, so we are looking at a substantial burden to the public purse just in those statistics alone. Untreated substance use disorders and mental health disorders in parents are highly likely to lead to the permanent loss of their children, which means that the public purse is maintaining those children until they are 18 years old.

Our figures show that we can rehabilitate a family for $175,000 for a 12-month period. On incarcerating mothers, it depends on where you look and the research does vary a bit. Depending on which website you look at, it can be about the same or twice as much. I am sorry I cannot give you a specific cost for that, because there does not seem to be anything that is firmly established. Our statistics show that 92 per cent of the women who have entered our residential program have ongoing or historical experiences with domestic and family violence. We know that those children, according to Fernandez and Lee, have a 73 per cent lower rate of being reunified with their parents.

**Ms KING:** What was the lowered percentage of families who are reunified if there is an active substance use disorder? Is it 86 per cent?

**Ms Eckert:** It is 86 per cent. It is quite shocking.

**Ms KING:** It is, isn’t it?

**Ms Eckert:** Mental health is slightly lower again. You can see that if you combine those three things, which is the cohort that we are looking at—that very complex case load where women are experiencing significant mental health, have experienced long-term historical domestic and family violence and have an active substance use disorder—you have that perfect storm of issues that they are trying to overcome without support.

**Ms KING:** My question is specifically about your model of care. Do women entering Grace Homestead need to have completed a period of detox before they come to you? If so, where and how do they do that?

**Ms Knorre:** Generally, yes. They go to either HADS through the PA Hospital or Moonya, which is the Salvation Army detox. We have not had great success with people completing home detox. We have had a few who have done a home detox under the care of their general practitioner. They have arrived and been drug tested and have tested positive, so that has not gone too well. I guess if they wanted to have quit substances they would have already, so asking them do it after 20 years for eight days before they come to us is a difficult task for them. Yes, we do take women who have been through a detox program.

**Dr ROWAN:** Thank you, Zoe and Christine, for all the work that you do and also for your submission, which clearly articulates the cost-effectiveness of investing in evidence based treatment programs. I think of Australian public drug policy. We talk about supply reduction, demand reduction and harm minimisation or investing in treatment services. In your submission you state—

> 72% of Grace Homestead's residents have remained substance free and continue to parent their children up to 2 years post graduation.

That is a testament to the great work that you are doing. We know that adverse childhood experiences are a risk factor for substance misuse later in life. Through these hearings there has been some testimony about a whole-of-government trauma strategy to look at various aspects, from health through to housing, education, corrective services and child safety. I refer to the clients that you see—the mothers and their family circumstances. What is the level of adverse childhood experiences amongst the clients that you see? Do you have any thoughts about a whole-of-government trauma strategy?

**Ms Knorre:** One hundred per cent of our clients have early childhood trauma and often they are multiple and severe. We know that coming into an environment that is calm and consistent is the first stage of trauma treatment. When we look at the way the brain develops, it develops from the bottom up, inside out. We need to be able to settle that lower part of the brain where we breathe and regulate our heartbeat, but we cannot do that when we are in an environment where we are being raided or where we have a partner who is abusing us. No. 1 is to create a safe space for women to begin to recover from that trauma.

In terms of a whole-of-government approach, there definitely needs to be one. However, for these complex cases it needs to be in a residential setting. These women have tried for years and years to reach out to services to recover in their own homes and it has not worked. For a small subset of the population, they do need this intensive, wraparound, long-term treatment.

**Ms Eckert:** The research shows us that, in terms of minimising the detrimental effect of children being separated from their mothers, a reunification program that establishes that contact, that permanency, within six months is the model that causes the least long-term damage. When we talk about stigma and those types of ongoing problems that develop in childhood and go into adulthood, a reunification plan that gets mothers into treatment as early as possible in a way that helps her children be reunified with her is the most beneficial. The problem is that the time line for treatment for the mother is usually about 12 months. What we want is for the child to be reunified with her as quickly as possible. Within that 12-month period when she needs to be treated, we need an active system that allows her child to be reunified with her immediately.

**Dr ROWAN:** With the mothers who are in treatment and have their children with them, how is the ongoing education and schooling of those children delivered?

**Ms Knorre:** We have a partnership with the local school and they would go off to either child care or school. Where we have children with behavioural issues, we work with the school around our behaviour management plan and making sure that the school is using trauma informed strategies to be able to manage any behaviours in the school environment.

**Dr MacMAHON:** Christine and Zoe, could you elaborate a bit more on the findings of the pilot study? It seems you have had some success, but are there other key findings that have come out of the program?

**Ms Knorre:** We are working with the University of Southern Queensland at the moment. We had our last graduate in January of this year. They are doing the data analysis for us at the moment. Some of the preliminary findings are that with anxiety and depression women will come in with extremely severe levels and leave with mild or normal levels. Craving levels would be down to zero within the first four weeks. We did see a fluctuation of that around the four-month mark. We identified that, because a lot of our women were methamphetamine users, as they began to eat normally they would put on weight. At the four-month mark, a lot of the women would be saying, 'Hey, I don't like the way my body looks. I feel I want to go and use methamphetamine again so that I can be skinny again.' While on the surface that seems like not such a big issue, that is really something that needs to be addressed from the outset, making sure there is a healthy eating and healthy exercise plan in place to make sure women are not relapsing for that reason. Trauma scores were reducing below the cut-off. Everyone came in with scores above the cut-off and most of them left with scores below the cut-off. Parent and child connection had improved significantly. Again, these are preliminary findings so we need to wait for those to be released from USQ.

**CHAIR:** I appreciate the work you are doing and I am sure all the committee does. We appreciate the time you have taken to present here today. Certainly we can see the value in a service that keeps parents and their children together. Thank you very much.

## KAVANAGH, Ms Rebecca, Board Member, Queensland Injectors Voice for Advocacy and Action

## KILL, Mrs Emma, Chair, Queensland Injectors Voice for Advocacy and Action

## PARRY, Ms Niki, Treasurer, Queensland Injectors Voice for Advocacy and Action

**CHAIR:** I welcome representatives from the Queensland Injectors Voice for Advocacy and Action. We only have 20 minutes. Can we skip the opening statement and go straight to questions?

**Mrs Kill:** Can we?

**CHAIR:** Yes. We have read your submission.

**Ms Parry:** Does that mean you have lots of questions?

**CHAIR:** People always have lots of questions.

**Mrs Kill:** Cool.

**CHAIR:** In terms of people who are injecting drug users, what are the issues around the availability of alcohol and other drug services in Queensland?

**Ms Kavanagh:** It is lacking. With specific services, we do not have nearly as much as we need. That has always seemed to be an ongoing issue. We need probably more focus on harm reduction services. That is really underfunded. We do not have nearly enough. Is there anything that you guys want to add to that?

**Mrs Kill:** I think it is really lacking in regional areas as well. Throughout Queensland the availability of services is really restricted to times. We are not actually meeting people where they are at. I think it is really underfunded. The evidence is that it works, especially harm reduction in the injecting drug user community. Harm reduction works and it works economically as well. There is a lack of services throughout Queensland, especially in regional areas.

**CHAIR:** When you say 'harm reduction' that is things like needle exchange programs and those sorts of things? Is that what you are talking about there?

**Ms Parry:** Not limited to but can include that, yes.

**CHAIR:** What else is involved in harm reduction?

**Ms Parry:** I think harm reduction is a way of working, essentially; it is a framework for a way a service works. It is often put in opposition to abstinence or a different approach to abstinence based services or other models. It is essentially meeting people where they are at and working with practical, realistic goals for people around their substance use and essentially being less focused on the drug use itself and more focused on improving people's overall health and reducing harms. A lot of the harms are those social harms for people which do not come from the drug use itself but come from stigma and not great drug policy, essentially. Harm reduction is about identifying those kinds of systemic changes as well and where you can make improvements in people's lives.

**Dr ROWAN:** Thank you very much for all the work you do around harm minimisation because it is very important for many Queenslanders. Can you outline some of the barriers that you see in relation to opioid substitution therapy or pharmacotherapy treatment in Queensland and what solutions you think are necessary?

**Ms Parry:** I would love to!

**Mrs Kill:** I will start and I think Niki would like to have a few words.

**Ms Parry:** We could have an hour on that one!

**Mrs Kill:** Even though we are here as a lived experience, we all work professionally in the alcohol and other drug space. I come from a regional area. If you want to get onto a medicine—and that is what we are talking about, a medicine—you cannot even get on a waitlist. You cannot get on a waitlist. You are lucky if you can get on a waitlist to see someone within maybe six months. I think Niki said it before: it is about meeting people where they are at. We are talking about people who want to stop using their substances, who recognise that this is the treatment and want to access services, and every day we have to say, 'Oh, sorry. If you can travel to Brisbane, you might be able to.' It is restrictively priced and it is under-resourced.

**CHAIR:** Which region are you from?

**Mrs Kill:** Sunshine Coast.

**Ms Parry:** I think some of the challenges currently around opioid treatment are because, as Emma says, the system is strained and at capacity. There are huge amounts of stigma. We are not seeing doctors wanting to become opioid treatment prescribers in the numbers that we need them to, so doctors who are opioid treatment prescribers are often overwhelmed, their appointments fill up really quickly and they are often unable to provide holistic care for people because they are just so busy. The administration around opioid treatment and working with people who often have a whole range of physical and mental health needs going on is really challenging. Access in itself is difficult; there just are not the services available.

**Dr ROWAN:** So greater access to opioid substitution therapy in both the public system and the private system as far as provisions needed across rural and regional Queensland?

**Ms Parry:** Yes.

**Dr ROWAN:** I also noticed you mentioned Naloxone. Should Naloxone also be provided alongside or at needle syringe program dispensing sites to address risks of overdose, particularly in relation to opioid drugs?

**Ms Kavanagh:** Absolutely. At the moment QUIHN, which is an alcohol and drug service which has needle and syringe programs, does provide Naloxone. That has only been recently, in the last two years, but it should be provided at every needle and syringe program, whether it is government or non-government. It should also be provided at every opioid substitution therapy program. GPs need to be more educated around it as well. Regardless, if someone is on a prescribed opiate they should be provided that as well.

**CHAIR:** Are you saying there should be the ability for someone to take Naloxone home, as opposed to just having it available on site?

**Ms Kavanagh:** Yes.

**Mrs Kill:** You are currently able to take it home. People come into service, they are supplied some training and they are able to take the Naloxone home. There is no point in the services having the Naloxone because people are using the drugs in their home. We have had parents come back into the service who have said thank you and asked for a resupply because they have been able to save their son’s life because they had it.

**Dr ROWAN:** For the benefit of the committee and for those who do not know, can you outline what Naloxone is used for, what it means for someone in that particular circumstance and also how it would be administered?

**Mr MOLHOEK:** I am just trying to work out how to spell it, Christian.

**Ms Parry:** N-A-L-O-X-O-N-E, otherwise known as Narcan. It is essentially an antidote for opioid overdose, so it is a life-saving medication which comes in intranasal and intramuscular formulations. Either are effective in reversing the effects of an opioid overdose. We need to get it into the hands of people who use opioids and their family and friends, yes. It saves lives.

**Mr MOLHOEK:** I wanted to ask what your connection to QUIHN was, if there was any, but you have subsequently spoken on that. We have a QUIHN here on the Gold Coast. They had a big launch about 18 months ago and are certainly increasing their profile and their presence. I noticed the other day they are even advertising now, I think on Triple M, for in-home services. I am interested to hear some commentary around the value of in-home detox services and how effective you think they are or may not be, and the benefits or otherwise.

**Ms Parry:** The research shows that we need different models of detox and withdrawal services. The current residential withdrawal or residential detox works for some people, but we need to really expand and think creatively about how we are able to provide detox and withdrawal programs for people and have a range of options that meet different people’s needs. Often residential detox will not meet the needs of people who have rental properties or pets or children, so having at-home detox and flexible ways of delivering detox and withdrawal programs is really important.

**Mrs Kill:** Probably you have heard through your time that rehabilitation and detox units are pretty full; they are at capacity. Many rehab services require you to go into detox first, so we lose a lot of people in that space because you have to go and do detox and then we have to coordinate to go into a rehabilitation service. At the moment in some areas there is still a massive waitlist. When somebody is ready to go into rehab or detox, they need to go pretty quickly. We do not want to lose people. Home detox is important for people, especially people with children or other work commitments. People who use drugs still have other commitments.

**Mr MOLHOEK:** You make a comment in your submission around decriminalisation. Recently we met with people from Townsville prison in regard to a program they were running there. I think the statistics were something like 90 per cent of all the people who were in prison had previous experiences with drugs, and then 70 per cent of those had experienced sexual assault or domestic violence. Do you have any views around whether it is decriminalisation or better ways to manage people who have had drug related issues, who have ended up in the prison system perhaps because of their drug use or because of charges relating to drug use, and whether there are more effective approaches?

**Ms Parry:** We see that for people coming out of prison who have drug use concerns there are often huge barriers for them in the way to reconnect with community. They often come out without a place to live or have inappropriate accommodation. There are often huge barriers in the way for people re-entering the workforce or studying—for example, blue cards, criminal history checks and things like that. Doing those basic things and trying to re-establish themselves in the community can be really challenging. QIVAA supports anything that is working towards less punitive policies, essentially.

**Ms Kavanagh:** And keeping people alive and safe. We would all like our nephew or our cousin or our aunty to be able to access something that is safe, and the only way for that to happen is for it to be regulated and taken off the illegal market.

**Mrs Kill:** The current policy creates stigma and discrimination. It is not economically viable. It is not actually winning, if we want to say it, the war on drugs. It is not curbing supply or use; it is actually creating a lot more harm than the actual drug itself. You would have seen models such as that in Portugal—there are different models—but I think in Queensland we really need to start having that serious conversation about drug law reform. It is a policy that is not working and is not evidence based. It is not evidence based. We need to have that courageous, honest conversation to see what the future could look like within Queensland.

**Dr MacMAHON:** Your submission talks about how the harm of drug use mainly comes from social policy and legal responses rather than the use itself. Can you elaborate on people’s contact with the Police Service and the medical system as well and how this might be creating harm?

**Mrs Kill:** This week a regional newspaper published the names and photos and outlined people’s mental health and a list of charges of what they described as ‘ice heads’—pictures of young people on the front page of a paper. This is really condemning them to a life sentence. A lot were in the past, so we are not talking about immediate substance use there. That is a really good example of how that sort of stigma and discrimination can keep impacting. It is really hard, both professionally and personally, if you have been convicted of a substance—the monitoring, especially with child protective services.

**Ms Parry:** I think it prevents people from accessing health and care. We see it every day. People are too afraid to access the health services they need because they cannot talk to their GP or health provider about their substance use. They fear judgement and stigma, and there are many ways in which stigma manifests in the health system. Essentially, people who use drugs will put off what can be a basic, easily resolved health issue and leave it until crisis point because they are too scared to access a health service. That stigma is pervasive across so many mainstream health services. We see it every day: people are refused services or provided with inadequate care or have their personal information disclosed to other providers—things like that.

**Ms Kavanagh:** There needs to be widespread training across all GPs and hospital services around drug use and what it is because I think there is a lot of panic. You would go to your GP and you would disclose whatever, that you are using this, and there is that sense of panic. The GP does not know what to do about it and will be condemning of it: ‘You must stop!’ That is not helpful. There needs to be a lot more education and a lot more training.

**Mrs Kill:** Also people are refused or are rejected services, especially in the domestic violence space. Every day in our work environment we have to really advocate for people, but they are refused access to shelters because of their substance or criminal history. People are not accessing services. It is really sad.

**Ms Parry:** I think the relationship between mental health and drug and alcohol sectors can be challenging as well. Sometimes with mental health services, even crisis mental health services, often there is an unwillingness or an inability to work with people’s substance use in addition to their mental health. We find that that is a real issue and a real barrier as well in how drug and alcohol and mental health services work together.

**Dr ROWAN:** Can I ask about medically supervised injecting centres? Could you outline the evidence base of what they can mean as part of a harm minimisation approach?

**Ms Parry:** The evidence shows that injecting centres or drug consumption rooms save lives. They in fact do not increase drug use in an area where they are. There has not been a single fatality at a medically supervised injecting centre across the globe. They in fact connect people to services that they need because they are providing a space for people to get that non-judgemental health support and care.

**CHAIR:** Thank you very much for the submission you have made and the work that you do in the community. Thank you for taking the time to present here today. It will certainly be very useful for the committee's report going forward. Thank you.

**Ms Parry:** Thank you for having us.

**BELL, Dr Lorraine, Senior Policy Adviser, Cancer Council Queensland**

**HANLEY, Ms Brigid, Senior Manager, Cancer Support Services, Cancer Council Queensland**

**PHILLIPS, Ms Kirsten, General Manager, Consumer Programs and Partnerships, Lung Foundation Australia**

**THOMPSON, Ms Emma, Chief Executive Officer, Arthritis Queensland**

**CHAIR:** Good morning. I would like to welcome representatives from the Lung Foundation Australia, Arthritis Queensland and the Cancer Council Queensland. You have made a joint submission. I ask one of you to make a brief opening statement in relation to that and then we will go to the committee for questions.

**Ms Phillips:** Good morning, Chair and committee members. I am Kirsten Phillips. Before I begin, I would like to acknowledge the traditional owners of the land on which we meet today and pay my respects to elders past, present and emerging. I am here today representing the Lung Foundation Australia as the only charity and leading peak body of its kind in Australia that funds life-changing research and delivers support services for people living with any lung disease or lung cancer.

The reality is that it affects about one in three Australians who experience a lung disease and it is the second leading cause of death. It obviously causes significant burden to the community and to our health system. We have been in the business for 30 years and in that time we have connected nearly a million people to our resources, support services and programs.

Today Emma Thompson from Arthritis Queensland, Brigid Hanley and Lorraine Bell from Cancer Council Queensland and I are speaking together on our shared priorities. As an alliance of not-for-profit health organisations, we did make the formal submission No. 126 and today we will be speaking further about those key priorities.

As an overview on the mental health needs of people with chronic conditions and the need for greater care coordination, currently chronic diseases are the leading cause of illness, disability and death in Australia, with respiratory disease, cancer and cardiovascular responsible for the highest rate of death and disease. With almost half of Australians reporting one or more chronic conditions, there is indeed a great deal of burden.

A key message today from our team is that people who experience chronic conditions also commonly experience the poorest mental health. The evidence is there. It shows a clear link between poor mental health and living with a chronic physical condition. We know that one in three adults who have multiple morbidities would also experience high or very high psychological distress. It does go both ways: as reported by the Productivity Commission, people with a mental illness are more likely to have a chronic disease. We can see that the connection is clear and commonplace.

In our field, in relation to a very common lung disease, chronic obstructive pulmonary disease or of COPD, the prevalence of a panic disorder is 10 times more likely, and that is commonly experienced due to the increased anxiety around the perceived or actual inability to breathe properly. We hear from our community that the decrease in independence and ability has a direct impact on day-to-day mental health, taking a toll physically, socially and emotionally. From research we have commissioned, two in three people living with a lung condition report negative impact on work and their ability to work, and more than 50 per cent report negative impact on their social and day-to-day activities like getting to the grocery store.

We know that COVID-19 has had a massive impact on mental health. It has been well documented the increase in social isolation, reduced face-to-face support services and disruptions to regular treatment, and this has been really felt acutely by our communities, and still is as we move into the endemic phase.

We know that the needs of our communities are unique and, while there has been an investment in mental health support services, it has been directed more to general mental health. More needs to be done to ensure that the mental health needs of people with complex medical conditions are met.

I would like to highlight collectively the importance of care coordination. A whole-person approach is essential in treating and empowering self-management of people's physical and mental health. Too often treatment solely focuses on the physical aspects of chronic disease and it leaves that mental health need undiagnosed and untreated. We want to reiterate here the referral pathways that are needed to ensure there is that whole-person approach to all aspects of health.

We also emphasise that it should be tailored and based on the presenting need. Often it is really hard for a person to engage in a complex, multifaceted treatment approach for a physical need when their mental health need is more pressing and perhaps even more—indeed, overwhelming. Ultimately it reduces the benefit of that prescribed treatment. A holistic approach is almost absolutely needed to ensure those outcomes are maximised.

There are many challenges for the Queensland community in this space and we know that there are unique needs and complex care requirements. When a person is diagnosed with a chronic disease, their world is turned upside down, and timely support that specifically addresses their mental health needs is absolutely critical.

**Ms Thompson:** Good morning, committee. My name is Emma Thompson and I am the CEO at Arthritis Queensland. We represent the 730,000 Queenslanders living with a form of arthritis, which encapsulates over 120 different diseases. Arthritis and musculoskeletal conditions are some of the most common, costly and disabling chronic conditions in Australia. While there is no cure for any form of arthritis at the moment, we can do so much to treat and prevent its burden. Along with the other chronic health conditions, a diagnosis of arthritis leads to an increased risk of negative mental health outcomes. Because we know that people living with chronic health conditions are vulnerable to negative health outcomes, there is much that could and should be done to support prevention and early intervention.

Tailored, person centred approaches are vital to support the wellbeing of this particularly vulnerable group of people. There is no one-size-fits-all approach that can be adopted. People with chronic health conditions need access to a broad range of support. These span the spectrum, starting with lifestyle intervention to encourage positive behavioural change, peer support, counselling, clinical psychological and psychiatric services, step-up step-down and crisis support.

Organisations such as ours play important roles in providing services which focus on early intervention and resilience building. Through programs such as peer support and specific counselling services, we can work to address the individual wellbeing needs of people living with chronic health conditions. Peer support programs, often volunteer led, evidence based and scalable, are very cost-efficient ways to provide emotional support by connecting people in person, online and via phone. We can see people seeking support benefiting from the connection to a person who has been in their shoes and who really understands their situation. Peer support is also beneficial not only to the person seeking support but also to the person providing that support.

Specific counselling services that address the specific needs of people facing life with chronic health conditions are a key part of the patient's healthcare plan. Generalised counselling services often fail our cohort of people because people feel that there is a lack of understanding of areas such as disease progression and complex treatment pathways which can really impact people's wellbeing. We are calling on the committee to recommend funding and policy changes to support the delivery of tailored, person centred support programs for people living with chronic conditions.

Chronic conditions do not just impact the wellbeing of the person receiving the diagnosis. One in 10 Australians are informal carers to people living with a chronic health condition, and research indicates that carers' wellbeing is directly impacted by the physical health of the person they care for. An example is that people caring for a child with juvenile idiopathic arthritis experience higher rates of anxiety and depression, and some studies have shown that up to 25 per cent of mothers of these children are taking antidepressant medications. Adult and child carers are impacted heavily by their roles. Thirty-nine per cent of carers report that they have experienced a change in their own physical or emotional wellbeing as a result. While there are some services available to support the wellbeing of carers, our experience indicates that awareness of them is low. We call on the committee to acknowledge the vulnerability of the mental health of carers and increase the support services available to them.

Finally, we know that chronic conditions are most prevalent among the most disadvantaged members of our community. As socio-economic disadvantage increases, so does the prevalence of multimorbidity. Priority groups, including First Nations people, homeless, unemployed, rural and remote communities and LGBTIQ people, are often facing increased risk factors from numerous chronic conditions and, as a result, their mental health is more vulnerable. A whole-of-system approach is required to understand the broader social factors impacting these groups and to produce tailored, person centred outcomes, and we call on the committee to recognise the specific needs to improve the access to care for priority groups and the need for tailored services and solutions.

**Ms Hanley:** Good morning, Chair and committee members. My name is Brigid Hanley. I am Senior Manager at Cancer Council Queensland. Cancer Council Queensland is dedicated to improving the quality of life of people living with cancer through research, the provision of information and support and certainly actively promoting prevention and early detection. I am going to speak specifically about workforce capacity issues and I am speaking from the experience of delivering cancer counselling services.

There is a recognition certainly for a greater need for psychological support for people who have chronic health conditions, but a key barrier to accessing support is workforce capacity, meaning psychology and counselling services are stretched due to the current demand and there are long wait times, especially for new referrals. We have noticed an increase in demand and we believe it is due to three key issues, the first being the pandemic. Before the pandemic, one in 100 psychologists were unable to accept new patients. It is currently reported that one in five are now unable to accept new patients. We also see that some psychologists have waitlists of up to six months.

The introduction of the telehealth Medicare items provided the ability for sessions to be delivered by telephone. We know that prior to these items being introduced there was a requirement on distance, so the psychologist had to do one appointment face to face in those first four sessions. We know that this introduction of now up to 20 sessions under a mental healthcare plan in a calendar year means psychologists have clients for a longer period and they are booking their concurrent appointments and their calendars are filling up.

On top of this increased demand are recruitment and shortage issues, specifically to meet the needs of people with chronic health conditions. We attempted in 2021 to recruit. We had three attempts in Cairns, two attempts in Brisbane and one attempt in Rockhampton and from all of these we only had one successful recruitment. Of the people who applied, a number were new graduates who are not suitable for the roles to support people with chronic health conditions, and many of the applicants had general experience but did not have the specialist psycho-oncology or health psychology.

In terms of the pressure on community counselling services, we are seeing additional pressure now being placed on community based services due to the lack of availability in private and other services. The following case illustrates the extent. Recently a health professional contacted us. They had made a referral for a private patient to a community mental health service. The wait was up to two months for a first appointment. The health professional then decided, ‘I will make a referral to Cancer Counselling Service. We are finding they are trying to use short-term services to fill the gap for people who require long-term services.

The other thing to highlight is the mental health needs of workers themselves. The current demands are placing a lot of pressure on the existing workforce delivering mental health care, with many maximising their number of sessions per day, and that is increasing the number of people they are seeing per day. This has associated pressure on their own mental health and this could, of course, lead to burnout. A recent survey noted that about 87 per cent of psychologists worked a greater number of hours in 2021 than in 2020, and 37 per cent felt that their own mental health was a little worse than in the previous period.

In terms of the training of health providers to understand comorbidity, there is a need for greater training of health providers who provide care to people with mental health conditions and other chronic health conditions to recognise specific issues and to refer to appropriate services. We know, for example, that mental health professionals report not knowing enough about cancer screening and the available services and the impacts of treatment. Similarly, people living with a mental illness report that cancer screening services often do not have an understanding of their situation, nor the psychological symptoms and the side effects of the treatments they are having. Cancer screening professionals then say they do not have training in mental health. Therefore, there is a greater need for the training.

We are calling on the committee to recommend increasing mental health services for people and particularly for those with chronic health conditions. This not only includes psychologists and counselling but also peer support programs, as mentioned by my colleague. Those who have that lived experience can provide extremely valuable support which is evidence based. We are also calling on the committee to raise awareness of the role and the appropriateness of the role of short-term services in the bigger mental health space.

**CHAIR:** I want to break down some of the disease processes a bit. If we think about chronic illnesses that might be related to lifestyle factors—COPD is potentially one, stroke, diabetes and those sorts of things—are you saying there is a high correlation between those types of illnesses and people with mental illness and because the physical conditions have created stress that has created the mental illness? Or is it because in some cases people had mental health challenges, and that has meant they have engaged in lifestyle practices that have led to those diseases?

**Dr Bell:** I think it can go both ways. Both can be the case. Yes, it is definitely the case that people with chronic health conditions have mental health conditions as well. Which one comes first is not always known.

**Ms Thompson:** We probably cannot speak definitively to causation, but it does emphasise the need for preventive health to be a priority in all aspects. If we can keep people physically healthy then we believe we can also support them with their mental health.

**CHAIR:** Then you have things like asthma and arthritis, which create pain, distress and discomfort. Those things can then lead to people becoming mentally distressed and potentially mentally unwell.

**Ms Thompson:** Yes, there is definitely a correlation between the two. As Lorraine said, people who already experience mental ill health are more likely to develop a chronic health condition or multiple conditions. Similarly, people who develop multiple physical chronic health conditions are more likely to develop mental health or experience worsened mental health outcomes. That sounds a bit cyclical, but we would argue that the same approach is required for both cohorts of people, which is preventive early intervention and then appropriate treatment for those who need ongoing treatment.

**CHAIR:** Then you have cancers and diagnoses of things like that which for many people, regardless of the validity or not, in their own minds are immediately life-threatening and obviously trigger stress responses and those sorts of things. In a hospital context, public or private, if you are diagnosed with cancer or you are coming back in for ongoing treatment, if you are in and out for asthma or arthritis, the hospital services have access to counselling services. The social work services I know have used consultant liaison psychiatrists on numerous occasions in inpatient settings. Are we looking for more services internally, in inpatient settings?

**Ms Hanley:** I would say yes. I was speaking to clinicians in a region of Queensland only last week. Inpatients have access to social workers. They do not have access to, in this setting, a psychologist, so these people who require psychologists are referred privately. Private practitioners have long waitlists. They do have liaison psychiatry, so again it is not consistent across the board. If you did implement a program of systematic screening of people with cancer at touchpoints at the beginning and at a time during treatment and then used an anxiety and depression screen to refer, a percentage of people's needs will be addressed by social work but there are those who require psychology and/or psychiatry. We do not have consistency across health settings. It would be the same for other chronic conditions.

**Ms Thompson:** Yes, absolutely. We would all be proponents of a multidisciplinary approach to health. We would love to see people at the moment of diagnosis not only getting the specialist physical treatment they require but also getting immediate support for their mental wellbeing through resilience developments. We feel that we as organisations have a great role to play in that early intervention space. We cannot prevent everything, but if we could support people to deal with the initial stages of being told that their life has changed forever then we feel that we could make a real difference.

**CHAIR:** That is fair enough. In major metropolitan hospitals where we have access to good psychiatry backup and you have really no great difficulty getting a consult within a day or two if that is what you need, it really comes down to your treating team identifying that. It would seem to me that oftentimes treating teams are focused on the cancer, the arthritis or the asthma rather than the psychosocial issues.

**Ms Phillips:** I think the other thing is that you have to put yourself in that situation. If I am in ED because of an exacerbation of COPD and they say, 'You should talk to a social worker as well,' if I cannot breathe at the moment then I need to sort that out. Then when I am back at home and I am more in control, I am in a position where I can reach out to a community agency that might not be as threatening. I think it is about just having different pathways for people to get in where they need to, how and when they can. Certainly, as Emma said, we see that as a key role for the NGO space where we can say, 'Make sure you call the Lung Foundation,' because we have those sorts of community models of care and support in place to always augment where they can get back into in the health service. As Brigid said, now that this person is in that space, what is the level that is needed to address the complexity of what has just happened to them, I suppose?

**CHAIR:** That is relevant to the community space. When people get a diagnosis of cancer, they go home. Sixty per cent of them ring their friendly nurse, whom they know, after they have adjusted to hearing the word 'cancer', and most of those nurses would say, 'You should ring the cancer foundation.' You are suggesting quite strongly in your presentation that there is just not the availability of people to refer on for people who need that psychosocial support.

**Ms Hanley:** I am sorry, could you repeat that?

**CHAIR:** When people ring you for advice, a need for psychological support is identified and referrals are made, you are saying there is no-one to actually refer on to in a community based setting?

**Ms Hanley:** We provide a service in a community based setting. We have a counselling service that handles up to 1,000 referrals a year, but, again, there are gaps. We will provide that short-term cancer-specific counselling. If someone has pre-existing depression and they are referred to us, we will deal with the cancer-specific issues that are exacerbating that depression, but this person may need help in the longer term so that is often where a gap comes in. We are a short-term, targeted service. What we need to do is continue to care for people on a longer term basis, because there is no referral we can link into.

There are definitely gaps. It is not just the hospital. The hospital is very much focused on the person with the condition, but it is also their partner and family member. That impact flows on to them. The hospital setting itself is very focused on that. It is again community organisations that have to pick up the support needs. Our role is to support that family, and they also have rates of anxiety and depression or may also have pre-existing mental health conditions.

**CHAIR:** In your submission I certainly acknowledge issues around navigation. There have been navigation roles created in Queensland Health over the last six to seven years. How have these impacted on the people who utilise your services?

**Ms Thompson:** I think the nurse navigator roles are fantastic innovations but they are not enough. They are still only accessible, really, to people who are already in the system. They are accessible when people understand they exist and if there happens to be a nurse navigator role available to you in your hospital setting. The beauty of our organisations is that we have no barriers to access. Anybody can call us on our free phone numbers. Our teams are extremely skilled at understanding what our role is and what other people’s roles are. Would we like to see more nurse navigators? I know that our organisations would. I am sure down the road we would, but it cannot all fall on the hospital system. We take responsibility for the role we can play; we just need to be supported to do it.

**CHAIR:** Do you have a question, Deputy Chair?

**Mr MOLHOEK:** I am just sitting here reflecting on the heartache of some of the chronic conditions you all represent. I wonder if we need to distinguish between mental health and a mental health episode versus what is just—not ‘just’ because I do not want to trivialise it—normal life experience. In their submission the Royal Australian and New Zealand College of Psychiatrists said it is important to define the difference between mental health, mental illness and mental wellness. I almost feel like we need to add another category and perhaps call it bad luck or life experience. I guess I just worry about whether we are putting the mental health label on too many things and whether—while what you are talking about is really important—it is actually mental health. I am sure there are cases where it is mental health, but I wonder more broadly whether for some of those people who come and see you because they have just been diagnosed with cancer or they have significant lung issues or respiratory issues—which probably have not really come as a surprise to them—that is the right label to put on some of these life events, for want of a better term.

**Ms Hanley:** I agree. Within our space we use the term psychological distress. That is a normal response to a cancer diagnosis, but it is on a continuum. It ranges from very normal responses such as being worried, being sad, being teary, all the way through to acute crisis where you are suicidal. Yes, there is a continuum and not everyone needs psychiatric support. What we have said—and I think a number of the proposals address this—is that you need an integrated continuum of care. Just because someone has normal distress does not mean they do not require any support. It can be speaking to someone on a helpline, having a resource that provides them with some coping so they can go away and their distress will subside and they will manage that concern themselves. We need those resources to help people manage their own concerns. For those people for whom that is not effective there needs to be alternative options, and that might include online interventions—I know QUT has made a submission—such as peer support, a lower intervention delivered by, in our case, nurse counsellors up to psychologists and then psychiatry. I agree: it is on a continuum. We do not want to stigmatise—distress is normal—but again remembering the continuum.

**Mrs McMAHON:** Following on from that is the role of support by family, friends and carers. Obviously with a chronic condition it is an ongoing process and there is no end in sight. For those who might have a more terminal diagnosis, that still may be a long period. I am wondering about the welfare and support for those carers, family and friends. I note there has been a lot of research around, for example, breast cancer and the role of peers in that space. I am wondering what is out there for carers and the role that peers play in working with those welfare and support groups.

**Ms Phillips:** Absolutely. Often it would be the daughter or the husband or the wife who would ring us rather than the person who is impacted. Then the person who is impacted would often say, 'Please talk to them. They are struggling the most, but they won't admit it.' For all of our services—the helpline and our peer support programs—deliberately the word 'consumer' includes anyone impacted by a lung disease or lung cancer. That is a family member, a direct carer or the person who is living with the disease themselves.

Peer support for those people can be with the person. You can turn up with your mum, your aunt, your husband or you can go to our carers group. You can talk to other carers about their lived experience as well. It would be absolutely integral to include them in any mental health support or any support more broadly. It is not just respite; it is actually counselling and talking through and relaying treatment to carers because often they are the ones who know how those regimes and whatnot work as well.

**Mrs McMAHON:** Do any of your groups actively seek out survivors or peer workers to work within this space? How do you have that conversation in terms of identifying? We have heard from peer workforce representatives that not all peers make great support people. Can you talk us through that process of identifying who is a really good peer worker in your space?

**Ms Thompson:** It is a really interesting area. We at Arthritis Queensland rely on volunteer peers. We deliver peer support programs online in online support group settings but also one-on-one telephone support where we match peers with people who are experiencing distress due to their arthritis. We have a strict screening process where we take people through several stages of interviews. Then we also train them in the fundamentals of peer support—understanding that we do not want to build a dependency here, that this is a system that is designed to help people move forward. It is designed to be looking around the importance of setting goals and addressing immediate needs and taking practical steps. It can be a challenge.

The number of suitable peers—applicants that apply—vastly outweighs the number of people who may be of any concern. They are an amazing workforce. I understand we personally do not use the paid peer workforce, but that is a great model. The volunteer peer workforce across Queensland is doing an incredible amount of work to support other people with lived experience of chronic conditions.

**Ms Hanley:** We do similar things. Often when people have gone through or finished treatment they want to give back. One of the ways they want to give back is through our peer support program, which may be by telephone. It may not be in that direct setting; it may be in another role such as being a volunteer transport driver, so they are still giving. One of the ways, aside from the screening, recruitment and training, is: has that person made space for that experience, made sense of it in their life and adjusted? Have they moved on from it and can they talk about that experience in a helpful way? Can they acknowledge how their experience shaped them but allow the person who is now newly diagnosed the space to talk? There is a whole range of skills that we focus on with our peers. They are a valuable contribution. Of course, the peers then know that they need debriefing, that they need support, and where do they step up to if the person requires higher level support from psychology?

**Dr MacMAHON:** My question is for the Cancer Council. Your submission talks about care for specific subgroups including First Nations communities. I wonder if there are any good examples from other parts of the country or the world where this is in place. If there are no good examples, what would you recommend?

**Dr Bell:** Good examples of—

**Dr MacMAHON:** Support for First Nations.

**Dr Bell:** Cancer Council offers our services, but we probably have areas where we could improve to make them more tailored for First Nations people.

**Ms Hanley:** I think one of the things is co-design. That is a big thing. You cannot just take a service and say, 'This works here,' and assume it is going to work for people of Aboriginal and Torres Strait Islander heritage. It is about co-design, so hearing the voices and understanding their experience is really important, as well as the mode of delivery. We have just started on this. We have an identified First Nations role within the organisation. We are currently looking across the board at our programs and how we deliver those. The areas we need to look at are about access. Are we recognised as a safe organisation by Aboriginal and Torres Strait Islander people? Is our service actually accessible? Just because we say to call, that may not be their preference. It may be face-to-face. We are at the beginning of that.

**Dr Bell:** Having multiple entry points, as has been talked about, is really important for that too—to be available in different ways for how people want to engage with the service.

**Ms Phillips:** One of the things we found real success with is engaging with Aboriginal controlled health organisations and NAATSIHWP as well. We would do respiratory inhaler device training with those Indigenous workers and then they would go out to community. It is more where people need it and how they want it rather than calling a helpline, which may not resonate at all.

**Ms Thompson:** We are interested in developing culturally appropriate access. It may not be that we are the right people to deliver those services and when we look at the demographic data of people who are accessing our services it does not align with the numbers that we know there is a need for. I know in the case of our organisation we are aware of our gap and that is something we want to address.

**Dr MacMAHON:** You have also mentioned financial support and that people with chronic diseases do take a big financial hit. What would be your recommendations in that space?

**Dr Bell:** Not surprisingly, people with chronic conditions face higher costs. The more chronic conditions someone has, the higher their healthcare costs. Even though we have our universal healthcare system, there are still gaps that add up and are quite high for people. On top of that there are also out-of-pocket costs related to transport. People who may have to travel far to access services have additional costs as well and supplements may not be covered by the PBS. There are lots of areas where the costs add up for people.

One important area is informed financial consent. Cancer Council Australia have co-developed a standard for informed financial consent, which is making sure there is transparency and communication for people to let them know about all the out-of-pocket costs they may experience so they can go into their treatment and understand where those costs might be and not be surprised by hidden costs. That is one area that can help. Also it is about linking people into services, because there are some support services that are available. In some cases people are not aware of them or there might be difficulty accessing them. I think there need to be greater links to services. That could happen through people accessing at the point of health care and just helping the awareness raising of the current services.

**Ms Hanley:** Another idea is certainly the pro bono legal program that is run through Cancer Council. It originated out of Cancer Council New South Wales, but anyone who contacts the Cancer Council or a health professional can be referred for assessment. I think it is also about financial counselling programs. We are about to pilot one that is really important. Programs like the patient travel subsidy needs to be reviewed regularly because often it lags behind. I know it has increased, but I think that was 10 years ago. We need to look at that as well with respect to people who are travelling by themselves. For those who are not coming with a support person, that out-of-pocket cost is considerable. There are a couple of things that are already in progress, but certainly it is about financial counselling and informed financial consent.

**Ms CAMM:** Thank you for your submission. I think you raised some very important points. You also highlighted some points that my colleague mentioned as well, one being that you have very few barriers to access through your own services but also the care coordination. You also mentioned the gaps in the system. From what I know and have heard from other evidence givers, people may actually have greater access to mental health support or services if they have a chronic disease than if they just have a significant mental health illness.

I come from a regional area, so when I hear the chair talk about being able to access a psychiatrist in a day or two I almost cry, because sometimes it takes us three to six months. When you talk about gaps, is it really the gap in the care coordination within either the private or the public health system that is, in fact, a gap in holistic care for chronic disease rather than gaps in accessing mental health services? Keeping in mind all that we understand about the workforce issues, that would be one of the most prevalent issues we have heard. Are the gaps around geographical difference in our state, or is it about standard of care and coordination across the state within the existing health systems, whether they be public or private?

**Ms Thompson:** It is both. We do not have models of care at the moment that support multidisciplinary care for people with chronic health conditions in every area.

**Ms CAMM:** In some there would be—

**Ms Thompson:** There would be some—

**Ms CAMM:** The McGrath Foundation with breast cancer is one that springs to mind for me where I know individuals have had exceptional holistic care, for example. But you are saying that is not consistent?

**Ms Thompson:** If you are diagnosed and have that experience, it would be very different to if you are diagnosed with rheumatoid arthritis, which can be a life-limiting disease and definitely a life-impacting disease. There are very different standards of care and models of care that apply and it really comes down to resources. Our specialists are amazing, but they are few and far between.

In answer to the second part of your question, yes, it is geographical. The workforce is disproportionately located in South-East Queensland. We know they are not in the places we need them. Telehealth has been fantastic, but I think Brigid's point around the patient travel scheme is a good one. That has not been reviewed since 2018 and I think we all can see what is happening with the price of petrol at the moment. There are increased strains on people accessing physical services. It is about models of care and workforce location.

**Ms Phillips:** The evidence shows you are exactly right. That is why at the LFA we have now pursued lung cancer nurses. People were saying, 'Where's my pink nurse? I don't have one.' We actually have a wonderful advocate who works with us who had, unfortunately, lung cancer and breast cancer in the same year. She is now advocating for us and has made some inroads in South Australia because she just could not believe the difference in moving between those two survivorship models. There is evidence that suggests that that care coordination, helping people in that time of crisis to access what they need—for sure. As Brigid was saying, if you could just screen at that point as well so people could know where they are going, could be directed and helped through that labyrinth of services as well that would be helpful. That is what the care coordinator does. Then there is the access.

**Dr ROWAN:** Thank you to all three organisations. I took away from the submission that with an ageing population with higher rates of chronic, complex medical conditions and resultant comorbid mental health issues when combined with reduced access and availability to health services and lower numbers of health professionals, particularly in rural and regional Queensland, you end up with poorer health outcomes. I have two questions. Strategically, when we think about our hospital and health services and our primary health networks—and it is not one or the other; obviously you want funding through both, particularly with respect to person centred support programs and those ones you have outlined in relation to counselling, peer support, families and caregivers—should that predominantly be within primary and community care? Is the investment needed throughout primary health networks as opposed to hospital and health services? What is the rough split in percentages of where the investment is needed? Ms Hanley mentioned the patient transport subsidy scheme—and that is a very important consideration with respect to higher fuel costs, accommodation and people having to travel. What specific recommendations would you have in relation to the patient transport subsidy scheme in Queensland?

**Ms Phillips:** In answer to the first question, it would absolutely be primary care. People can go to their tertiary centres. A lot of our pulmonary rehabilitation programs are located in tertiary centres and people do not access them because they cannot get there or there is a high cost of parking. Why would we put people in hospital if they do not need to be there? We need investment in primary care locally with your doctor and that wraparound multidisciplinary care—nurse, pharmacist, counselling, OT, physio. I am not saying take away funding from hospitals, of course, but if I listened to my community and reflected on what it is that would help them the most to keep them away from hospital, it would be having all that information there and then augmented by the community models of peer support, helpline, general information and knowing where to go to navigate that system. They would certainly be the thoughts from our community.

**Ms Thompson:** You will never find a group of organisations that can do a better job of making very little money go as far as humanly possible, which is what we can do. Community organisations and volunteer roles play a vital role; we are the bedrock of primary health. Quite often we are the people to whom people go first before they go to their GP. An investment in increasing our capacity to do the work we already know how to do would be a very smart investment, I think we would all agree.

In relation to the Patient Travel Subsidy Scheme—and this is slightly uninformed—I remember being involved in the review in 2018 when the system was computerised and digitised, and it is wonderful to try to improve access. However, the reality is that it has been a long time since the amount that is available per accommodation night was increased to $60; I think it is still the same amount. Very clearly the cost of living is a big issue at the moment. It is something that needs to be addressed with some urgency. People will make decisions based on whether they can fuel their car. They will make decisions between fuelling their car to get to their health appointment and putting food on the table. For some of our consumers that is a real decision to make, which is awful. The scheme is fantastic. It is designed to support people. We just need to make sure it is actually at the level where it does provide genuine support.

**Ms Hanley:** It definitely needs to be reviewed as a priority but also there needs to be consideration that some people will travel without a family member. The family member may need to stay home in regional Queensland to look after children or to maintain a property or a business. A person will then be by themselves, so their out-of-pocket gap is greater. We do need to consider that. Though we aim for someone to come with someone else, it is not always possible. We need to review that amount, and I understand that amount has not been reviewed for 10 years. I know there have been some other changes within the system. Then we need to look at people who come by themselves.

**Dr ROWAN:** It needs further indexation.

**CHAIR:** Thank you. We have exceeded the time allocated. Thank you for your appearance today and the time taken to make your submissions. Thanks for all the work that your organisations do in the community. It is tremendous work. It will certainly inform our inquiry going forward. Thank you very much.

**Proceedings suspended from 11.02 am to 11.15 am.**

## ABELL, Mrs Hayley, Director of Strategy and Advocacy, Mental Illness Fellowship Australia (via videoconference)

## BUTT, Mr David, National Chief Executive, Grow Australia (via videoconference)

## FRIEL, Mrs Sharon, Regional Manager, Eastern Australia, Grow Australia

**CHAIR:** Welcome. I invite each of the organisations to make a very brief opening statement and then we will go to the committee for questions.

**Mrs Abell:** Firstly, thank you for the opportunity to appear before the committee today. I am joining you from the lands of the Jagera and Turrbal peoples. I acknowledge the traditional custodians of the country throughout Australia and I pay my respects to them and their cultures, and to elders past and present. I also acknowledge the expertise of people, families and carers with lived experience of mental health conditions.

There are a group of 300,000 Australians living with severe and complex mental illness who require psychosocial supports to live well and experience a better quality of life. Of this group, over 150,000 Australians with severe and complex mental illness still do not have support in the community to enable them to live well and independently. People with severe mental illness are missing out because not enough services are available in the community and available services are not always suitable to meet an individual’s needs.

Those people are often invisible because they are considered too complex to be treated in the primary care system but are not considered unwell enough to be treated by acute services. There are no front doors to knock on, no queues and no waiting lists to join. There are limited choices for accessing mental health supports in the community early to support wellbeing, and often the only option is to wait for distress to escalate into crisis and to seek support at emergency departments. This invisibility and neglect has condemned thousands of Australians to social isolation, risk of homelessness, poor mental and physical health and reduced life expectancy. However, with the right psychosocial support in the community, people with serious and complex mental illness can recover their place in their community and live contributing lives.

Significant investment and a shift in mindset are required to support transformative mental health reform, both in Queensland and nationally. In our submission we advocated that the gap in psychosocial supports can be addressed through the development of a national psychosocial support program to support all Australians with severe and complex mental illness who are not eligible for supports under the NDIS. We urge this committee to recommend greater investment in community supports through this program so that people can access services in the community when they need them to support recovery and wellbeing.

We have seen governments in Australia agree to a national plan for mental health and suicide prevention. Unfortunately, the plan is short on solutions for people with severe and complex mental illness. The plan failed to contain any new investments in psychosocial supports. It does contain a commitment to a one- to two-year plan to further investigate and quantify the need for psychosocial supports before anything else is done.

The Productivity Commission spoke to the level of need in their analysis during the recent mental health inquiry and this is a good place to start. Now that governments have agreed to undertake this analysis work, it is important that we understand locally what the needs are. This is particularly important for a diversity rich jurisdiction like Queensland. Local planning at a community level is needed to identify the need and the gaps, with regional and subregional planning overlaid by estimates under a revised national mental health services planning framework. There is an opportunity to undertake this work in the local regions where adult mental health centres will be rolled out in Queensland.

We need rapid progress on this analysis of psychosocial supports now. MIFA and the sector want to work with all governments to support this work to be done quickly, well before the two-year deadline, and to co-design a national psychosocial support program to provide mental health supports in the community for people with severe and complex mental illness.

**Mr Butt:** I too want to acknowledge the traditional owners of the land on which we are all meeting today and pay my respects to elders past, present and future. I apologise that I cannot be there today. Lesley van Schoubroeck passes on her best wishes. Lesley is the chair of our board and knows a number of you from her past role as the commissioner for the Mental Health Commission in Queensland.

Grow is turning 65 years old in two weeks time. We are an organisation that was formed in 1957 by people with lived experience. You can imagine that in 1957 they were the days of seclusion, restraint, straightjackets, enforced injections, forcibly restrained, institutionalised. Not being happy about that approach, they decided to form their own approach, which was very much about mutual support. Grow is an intentional peer-to-peer support organisation. It was formed by people with lived experience way before expressions like 'co-design' were around. They designed it themselves. They delivered the program and that is still the case today.

We have a governance model that I describe as two parallel universes. The people with lived experience design the program, deliver the program and change the program. If they do not want to change it, I cannot change it and the board cannot change it. My parallel universe side of it is about having staff who support that process. A lot of them have been through the program so there is a lot of peer experience there. It is a peer support model. It is not an army of peer workers; it is actually an army of peer support people and so is very much on the volunteer side of things. People who are participants in the program are, therefore, there to provide mutual support, treat each other with respect, help each other and build community. By building community and by helping each other you help yourself in your own recovery journey. We know that it works. I think the commentary before from Arthritis Queensland, the Cancer Council and the Lung Foundation was very much about that peer support model.

People who have experienced something want the social connectedness and they want to build that community so they support each other because they have the same experiences. That is what happens. We know it works in mental health. We have helped tens of thousands of people to recover through Grow. You do not need a referral. You do not need a diagnosis, even though we know through our surveying and evaluations that a lot of the people in Grow have quite severe mental ill health problems.

We do not worry about length of stay. We do not worry about the number of sessions you have been to. You do not have to stop after six or 10 or 20. You can stay with us for as long as you need to. We have people with 20-plus years who have been with Grow. We are different. There are not many programs like that where you can just stay because it helps you to maintain your recovery, it keeps you in employment, it keeps you out of hospital and it helps you maintain your family. People also want to give back. They are volunteering to help others through their recovery. We never discharge people because they are long stayers. We never worry about their length of stay. It is an important thing.

We are there with people and we walk them through what is going on in their lives. That is what it is about. It is about a trauma informed approach, which is not about their diagnosis but rather about their life experience. A lot of people take a lot longer to recover because we are all individuals and we are all different, so we do not kick people out. It gives people agency over themselves. It allows them self-determination and autonomy. They not waiting for someone to do something to them. That is what a peer worker does: a peer worker is employed to do something to you whereas peer support, as I say, is quite different. It is about actually supporting each other.

The final point I want to focus on is that we talk a lot about workforce shortages. We have shortages of psychiatrists, psychologists, nurses and other allied health professionals, peer workers—whatever you like. The thing about peer support is that we have a ready workforce out there the whole time. Those are people who come into programs, into Grow for example, and want to look after each other. You saw it a little bit at the start of COVID. You saw people coming together and talking to neighbours for the first time in ages. It did not last, unfortunately. You saw it in the floods. I still have staff—and Sharon can talk to you about that—in the Northern Rivers. They were out rescuing people and looking after them in their own homes and then looking after their pets as they moved on and so forth. We have serious burnout. We have overwhelmed staff in the mental health sector, but you have a ready workforce.

We can reach and support anyone in the state because we have a ready workforce of people who are members of the community and who want to help and support each other. One of the great things about when the pandemic hit was that we were ready for it. We had eGrow ready and we were able to immediately swing groups into meeting online. We can reach anywhere in the state by supporting people online or in face-to-face meetings. We can do both. It is a ready workforce. We can equip it really quickly. We train, we support people and they go out and train and support others. It is there. The workforce is the community and that is what we need to do: we need to support the community to support each other.

Basically, at the end of the day, we are looking for your support in helping us to support more people to have access to a service such as this. Sharon, did you want to add anything?

**Mrs Friel:** On the peer support versus peer work distinction, I was discussing this with one of our program workers who is in Lismore at the moment. For a bit of context, this year already she has broken her back, got COVID, had the suicide of someone close to her, there was the one-in-a-100-year flood and she has a lived experience of mental illness. I would describe her spirit as strong and well. She credits it to the fact that she has learned so many strategies from the program and that she is in a community where everyone supports each other and it is not any one person's responsibility to carry the load. They are a community and they are a network. I discussed with her coming here today and she summed it up pretty well: the difference between peer support and peer work is that a peer worker is somebody who is paid to be your friend and a peer supporter is your friend.

Thank you for having me here today. I am very glad to be here. Grow has a long history in Queensland. We did hit a stumble in 2019 when we lost all our funding in an open-tender process. We were able to claw back some of it, which is fantastic, and we have been in a bit of a rebuild since then. The community has endured and that is because it is a community and not a service. We are here to help people thrive and we do that by stepping in and out of leadership where needed, but always we are there to strengthen the community to help each other.

What people in peer support can provide to each other that is not readily available with clinicians is the priceless gift of hope. If someone can communicate that they have recovered, regardless of what they have been through, then you know that it is also possible for you. What we aim to do is support that leadership and continue to enable communities to support each other.

Queensland has the second lowest expenditure on mental health community managed organisations of all states and territories. That does impact on our ability and that of other community organisations to maximise and build on the good that we are already doing. We would love to see psychosocial community organisations being taken more seriously in the mental health sector and for our voice to be heard as an equal contributing part. We are always adapting, largely due to the fact that we never have any resources. We have continued to do that with eGrow, which we have elaborated on and expanded. We have improved our digital capabilities and it is a very cost-effective statewide offering that we are very proud of.

What sets Grow apart from almost any other mental health organisation is our inclusive governance structure. To put it in context, every single word in the Grow program is written by people with their own lived experience of mental health. It is not written by clinicians; it is written by the people who have done the work, who have actually achieved it. Because of that it has a depth and a wisdom that just cannot be paralleled by people who have not walked that path themselves. It also shows the overwhelming capabilities of people with lived experience to lead their own recovery. Within Grow we have teams that govern aspects of the program, but it is all consumer-led.

It is important to note that people are capable of so much more than just filling a lowly position in a clinical team that sits in a waiting room with people before they can receive their actual treatment. They can be instrumental. What all of this contributes to as well is combating stigma, which is so rife in the mental health system. Many Growers contributed to the Sane report card on mental health stigma. It showed that 83 per cent of people experienced stigma when receiving health care in the last 12 months. That is not a small amount; that is a catastrophic amount of stigma. We are essentially saying to people, 'Go and seek treatment where you are almost guaranteed to be discriminated against.'

A lot of this is perpetuated by the categorical nature of funding and referral structures. You need a diagnosis to access certain services and you need a referral or a plan to access certain things. The system perpetuates the stigma; it does absolutely nothing to reduce it. In Grow we do not talk about diagnosis. You could come to Grow for 20 years and never disclose your diagnosis if you do not want to, because at Grow you are always a person first, and the thing that unites all people is the fact that we have problems.

We talk about the dividing line. The dividing line is not between sane and insane. It is not between addict or not. It is down in our own hearts. Every single person has the possibility to get into trouble with their mental health or to get into trouble with addictions. Because of that, we do not talk about diagnosis because it may not be relevant to the person. If you have a diagnosis of schizophrenia but you are having problems with your marital relationship, you come to the Grow group to talk about your relationship. You do not come to talk about your schizophrenia. That is such a powerful way to combat stigma because you cannot categorise anybody because you do not know their diagnosis, and they did not need a referral to come in the first place. I think that make us possibly the only organisation that operates in that way.

**CHAIR:** With regard to peer support, do you have standards of practice or codes of conduct? Do you have standardised training for people and ongoing support?

**Mrs Friel:** Yes, absolutely. We are accredited against the national mental health standards, as all organisations are that are funded by Queensland Health. Not only did we pass our national mental health standards; we passed with no recommendations. We are very confident that our governance is sound and that just because you are doing peer support it does not compromise your ability to do good governance. We have really stringent policies and procedures and guiding resources for whatever comes up, whether it is aggressive behaviour or an expression of suicidal ideation. It is all included within the program. We do regular training for people who organise groups to build on their leadership. It is just an ongoing process. If they ever have any concerns, their staff is there to help.

**CHAIR:** Hayley, you have used the term psychosocial support organisations. Is it fair to say that your organisations are not there to diagnose and treat specific mental health conditions in a medical model; it is more about helping people have companionship, sort out things that you need to sort out every day, like banking, and finding somewhere to live and working your way through any issues you might have in relation to employment, and by doing all of those things you have a positive effect on the mental health aspects without ever taking a pill or going through a counselling session? Is that a fair description of the psychosocial supports?

**Mrs Abell:** Yes. Broadly we refer to them as non-clinical options, although even we do not like saying ‘clinical’ and ‘non-clinical’. It is all about services or supports that can see the person as a whole and have a very individualistic and personal-led response to what they need based on their situation, what is happening to them in life and any barriers they might be experiencing in certain life domains. For example, if somebody is experiencing problems with keeping employment and that is something they would really like to achieve in their life—to have regular, secure, stable employment—then a psychosocial support service can work individually with that person, either one on one or in a group setting, to really unpack what are the barriers to them keeping or seeking stable employment, where they might want to develop their strengths further and what resources they have in their lives that they can draw from to give them strength and develop further resilience around keeping employment. They really are individualised responses to the person based on what is happening in life for them. It is very different from the support that you might get under a more clinical model. I am sure David might have much more to add to that.

**Mr Butt:** I just think you need to be a bit careful when talking about psychosocial support as being about community support because, even though we do not have a diagnosis, we survey our members and we know that more than 20 per cent have bipolar problems, almost 20 per cent have schizophrenia and so forth. When you are talking about psychosocial support, you are actually talking about people who may have some very severe mental ill health problems and who need all sorts of support. Yes, we do it through a model that is about friendship and building community and building social capital et cetera, but these are people who otherwise would be hitting emergency departments, going into hospital, because there are not many alternatives. I think that is one of the points Sharon was quoting.

In our submission we talked about the level of funding that is going into community based mental health organisations such as ourselves and MIFA. The amount of money has gone down. A fair bit of that went into the NDIS—we know that—but most of the people did not go into the NDIS. There are people who have gone into the NDIS and they are getting packages, and that is fantastic, but what about all of the other people who have severe and debilitating mental ill health problems? That is where the psychosocial support organisations, such as ourselves and MIFA, are trying to support people who have potentially very severe mental ill health problems. The level of funding available for them is not there.

**CHAIR:** I know that you do not ask for a diagnosis or anything of that nature at Grow. I am not sure about the member organisations of MIFA. Do you find there are people who arrive at your service fairly early on in their mental health journey—so they have been recently diagnosed, had a look around for support services or any services and found that there is not a huge amount out there and so turn to Grow or other organisations for ongoing support and opportunities to understand what they are going through to get support around that?

**Mrs Friel:** Yes. What I find with Grow is that the program is different things to different people. It is a program of self-activation, so it relies on you wanting to get well yourself. Then it provides a road map for you to do that, but you have to do it. You alone can do it, but you cannot do it alone. For some people it is the school of life. They want to address their more core egocentricities or really ingrained habits that are not serving them anymore. For other people it could be addressing symptoms of their severe mental illness, that they are trying to think by reason rather than by feelings or imagination. It is not that the program is for a certain thing; it is that people use it flexibly for what they need it for. That is the main thing.

**Mrs Abell:** The experience would differ across our member organisations, but certainly there are people from right across the life span from the age of 18, for our member organisations, who want to access support. The experiences are very different. Some people may have lived in institutions in the 1980s until they closed down, so they have had a lifetime of coming in and out of services or accessing supports. Others may be in their early twenties or their thirties, so a lot younger in terms of their mental health journeys. The thing I would say that is characteristic of each of our member organisations is that they do live by this ethos of wanting to help people in the community. They are often faced with the experience of having people come to them for support and they may not have the funding to deliver that support, yet they will still find a way to support people. That obviously can affect their sustainability in the long term, but there is very much a sense of not wanting to turn people away. Often a MIFA member can be an organisation of last resort for a lot of people who have the experience of being bounced around from service to service because they are considered too complex to support or too high risk to support for the organisation. Often MIFA members—and perhaps Grow is in the same situation as well—do become an organisation of last support to ensure that people do not fall through the cracks. That is being offered without funding.

**Mr MOLHOEK:** Hayley, in your submission you talk about the focus on building community. There is an old saying that it takes a village to raise a child. I worry that we are quick to put the mental health label on so many issues. I wonder whether there needs to be a greater focus on reconnecting community and getting people to become more actively engaged in community groups and activities. I would like to hear your thoughts on that issue.

**Mrs Abell:** Absolutely. That is a critical component of mental health and wellbeing. That is one of the important roles that community mental health organisations play in the work they do with people. At MIFA, for example, we advocate working within a recovery oriented framework. That work really involves support workers or peer workers working with people to understand what are the natural connections in their family, with their friends and with their communities that can be built upon so people can be reconnected. For people who have lived or are living with severe mental illness, often those connections are severed. They may have lost touch with their friends, their family and with the community groups they used to be involved with. It can really take something to get back in and get re-engaged and reconnected. That is a really valuable role that peer workers and support workers can play in supporting people to rediscover those relationships, which can really help with their mental health and wellbeing.

I agree: community is essential. Again it comes back to reinvestment in the community mental health sector to support those organisations to continue that really important work with people, which then may mean that over time the support they need can be tapered off. People may not need that really intense support all the time once they have been able to strengthen their resilience and their connection back in.

**Mr MOLHOEK:** David or Sharon, you talked about the issue of stigmatisation and the need to destigmatise mental health. I worry that, by putting that label on so many people or situations that people are facing, we are almost creating a society where everybody has a mental health issue. Are we going too broad with this? I would be interested if you could also touch a little on the funding that you lost around group programs.

**Mr Butt:** Everyone has a life issue. We run into stress in daily living. We have seen it particularly with COVID. We have had people coming to us who previously have not touched the mental health system but suddenly find that they need support because they are uncertain, they do not know about their economic future and all those sorts of issues. We deal with it in a trauma informed way, which says: it is not about your diagnosis; it is about your life experience. I know what you are saying. We are not going around saying to people, ‘You’ve got issues of discrimination’ or whatever it might be. People are coming back to us and saying that, even though they are getting support, they still have issues of discrimination or they are being seen as having problems and that impacts on their ability to get a job.

I think it has improved in relation to things such as anxiety and depression but not so much in relation to having a severe—anxiety and depression can be severe, but it is not so much when it comes to saying, ‘I am bipolar,’ or ‘I have schizophrenia’ or something like that. It is very hard for people to come forward and talk about those things. I will let Sharon talk a little about what she has experienced in Queensland, particularly with the funding in Queensland.

**Mrs Friel:** The Queensland Health mental health AOD department restructured some of the funding streams a few years ago. They released an open tender for group based peer work that was going to be allocated according to HHS. It was for people to be referred into. I think it was for up to eight weeks they could be part of a group based thing and then they would be referred back to an individual support program. Our funding, I believe, was rolled into that and there was a request for offer to tender for that. We were unsuccessful because our model was different. No. 1 was that it is not led by peer workers but is intentional peer support. It is a different thing: it is not time limited and you do not need to be managed by Queensland Health to be referred into it. It was just that there was really no way we were going to get funding for that because it is not what we do.

**Ms KING:** This question is primarily to Grow. I speak as somebody who had a family member participate in Grow in New South Wales over a long period. While I know that you do not focus on people's diagnoses or their degree of mental illness as Grow's way of interfacing with its participants, it is the case, is it not, that many Grow participants experience a level of mental illness that is significantly stigmatising for them in the community and a grave challenge for them in their lives? I am trying to speak to the questions of the member for Southport around whether we are overdiagnosing or calling everything mental illness. From my understanding of Grow—and I would love you to correct me if I am not right—many people who participate in Grow do in fact have very significant challenges with their mental health that impact their lives.

**Mrs Friel:** Yes, that is true.

**Ms KING:** Of course there is a lot more to those people.

**Mrs Friel:** There is.

**Ms KING:** I am not at all meaning to reduce that, but it is not the case that the majority of your participants are people who just wake up one day feeling a bit off.

**Mrs Friel:** Absolutely. We say in the program that the lowest ebb is the turn of the tide. Certainly for a lot of people, because self-activation is key, they find that activation only once their thinking has got so distorted or their life has got so bad that they are willing to do something about it. In saying that, a lot of people will maybe have an episode that brought them to Grow but they will then largely recover. They do still experience the ups and downs but they are probably not as severe anymore. I think the problems shift.

The program is a 12-step program. Your initial steps are to do with getting your own thinking right and the later steps are to do with becoming a fully functioning member of society. As you do that and you gain employment, you gain a spouse or whatever it is, you have different problems. Even if you have an episode or a diagnosis, it can be at a point in time but the problem is that the label stays with you even if you have changed a lot. Even with some of the symptoms—if you have paranoid thinking you do not have to have a diagnosis of schizophrenia to be paranoid.

**Mr Butt:** To add to that, we seek out. We go and look for people who are often at the hardest or the lowest point in their lives. We do hospital orientations. We go into mental health units that are seclusion units et cetera and we tell people, 'Here's a pathway out. When you come out, we can support you through this.' That is an example. We go into prisons and do the same thing. We have groups working in prisons and the like. We go into those hard places and we help people, when they come out and while they are inside.

**Ms KING:** On that broad topic but specifically around funding, it is my understanding that funding for Grow changed when the Queensland government had to cash out of some mental health services to cash into the NDIS and that that impacted the kinds of psychosocial support programs that you provide. We have had people make submissions before the committee about the fitness for purpose or otherwise of the NDIS when it comes to helping people operate in a recovery model. If your continued inclusion in the NDIS is dependent on you remaining sick, then models that focus on living a life of recovery and better integration in the community and overcoming challenges may not be a great fit. I wonder if you have anything to add to that.

**Mr Butt:** What can be more stigmatising than saying to someone, 'You have a permanent disability in mental illness'? The NDIS does not fit that model very well for the mental system. We know that. Mental ill health was added on as the last option in relation to the NDIS. It does not fit a recovery model all that well: 'You are going to keep your package as long as you are deemed to have a permanent disability.'

We lost funding. We would not know whether any of the people attending Grow actually have a disability package, an NDIS package, because we do not ask. We do not get paid by them. We lost funding but we did not lose the people who were involved in our program—other than that we could not support them all so we did lose some.

**Mrs Friel:** With the way the fee-for-service model is done for the NDIS, you are only able to charge while you are supporting that person. It really robs them of their ability to self-activate for their own recovery. If we have a setback we always encourage people to go and talk to their GP about the program or to support each other. They are doing that independently of us. They are always building those skill sets if they want to go back to work or whatever the case may be. However, if you are only funded when you are with the person you kind of rob them of a lot of ability to be instrumental in their own recovery.

**CHAIR:** The way I have heard it described by some people is that you have to write your shopping list for the next five years. If you decide this week that you want pizza, too bad. You put up your hand for roast chicken so that is all you are going to get.

**Mrs Abell:** I can add something to follow on from Grow's comments. MIFA has been working with the NDIA and others on the advisory committee that has been implementing the recovery framework for the NDIS. We are very hopeful that under this new recovery framework for psychosocial disability we will see a shift in the way that psychosocial supports are managed within the NDIS. Right now people are really fearful that if they get better they will experience incredible cuts to their packages or they will completely lose their package. We have a lot of work to do in shifting that focus around celebrating recovery and celebrating success so that people are not so afraid of actually getting better. That is one of the important things MIFA is advocating for in having a national psychosocial support program that actually sits alongside the NDIS and that is flexible, that has low barriers to entry, that does not require a diagnosis, that is inclusive of families and carers and that is person-led. Therefore, through the NDIS and through this national psychosocial support program, we can actually support the 300,000 Australians with severe and complex mental illness and support people to transition out of the NDIS or into the NDIS, if that is what they need, based on where they are at in their lives.

**Dr ROWAN:** Thank you to both organisations. I take this opportunity to acknowledge Grow's board chair, Dr Lesley van Schoubroeck, the inaugural Queensland Mental Health Commissioner. For part of the time of her tenure I was a member of the Queensland Mental Health and Drug Advisory Council. There was a tremendous amount of work in the establishment of that statutory agency.

In Grow's submission there are references to social connectedness and economic participation and how important those are for people living with mental health conditions or recovering from substance misuse issues. What can be done further to enhance employment opportunities and specific programs—whether that is for young people, older Queenslanders, people who may be coming out of prison—to ensure not only that social connectedness occurs but also that there is economic participation, given the importance of jobs and opportunities for people who are living with mental health conditions?

**Mr Butt:** Thank you for the acknowledgement of Lesley. That is a really good question. We do a couple of things. One is that we run schools based programs. We run Get Growing, which Sharon can talk a bit more about. It gets people back into schools and keeps retention rates high and gets them participating et cetera. The other thing we do is more about ensuring that people can participate in their families. Often they are disconnected, obviously, if they have lost their homes or they have lost their families. It is that connectedness with community that is so important. It is about building social capital, which is what we do. I think we could do more of that, particularly in a rural and remote setting, as I have said, through things like eGrow where we can reach out.

You know very well about the stigma that occurs in small communities. We have lost groups where two people have turned up at the same group meeting and they know each other from the community and they have said, 'I don't like him or her and I'm not going to sit with that person.' I think it is important to have the opportunity for flexible approaches to communities where you can do it on the basis where you are not stigmatised and you are not identified; you are actually just supporting each other. That is a really healthy start. I think eGrow would be a good example of that, where you can support people, and that helps them stay stable and able to go into jobs.

I talked about our hospital orientations. We do that in some hospitals, but we do not do it consistently across Queensland. The pathway out of hospitals and out of prisons into potential group support is a really important thing. If you strengthen those things and you make it routine, just as you might make Get Growing in schools more routine, you are going to develop a pathway that leads you into supporting people to get into employment and to stay in families and to look after each other. I think they are important aspects of that to begin with.

**Mrs Friel:** Just following on from that, step 10 is that we take a responsible place in society. It is built into the program. Your three vital needs—this is the code of our program—are somewhere to be safe and to be going somewhere. At a point in your recovery it is expected that you are going to take your responsible and caring place in society, and part of that is economic participation. Your group would challenge you at a point to say, ‘Get on with it. How do we help you to do that?’ It is kind of built in.

**CHAIR:** Thank you very much to both organisations for your time today. Thank you for the work that Grow does in the community. I see that frequently. Thank you to MIFA for all the work that your member organisations do in Queensland. The information and the submissions you have given us today will be very useful for the committee moving forward.

## GOMEZ, Ms Megan, Director, Rural Health Connect

## SWEENEY, Mr Brent, Chief Executive Officer, Outback Futures

**CHAIR:** Welcome. Could I ask both of your organisations to make a brief opening statement and then we will go to questions from the committee.

**Mr Sweeney:** Our core business is the mental health and wellbeing of Queenslanders, particularly for us at Outback Futures in remote and very remote areas of the state. We really welcomed the Rural and Remote Health and Wellbeing Strategy 2022-2027.

The stats show that mental challenges are faced pretty much equally by people who live in the bush and those of us who live in the city. The big difference is that outcomes can be many times worse in remote and very remote parts of Australia. In very remote regions, for example, you might be up to three times more likely to commit suicide than you are if you live in a major city. Our question is always: why is that the case? For us there are a couple of reasons, and they have already been touched on so I will not go into great detail on them.

There is a significant issue around access. People in remote and very remote areas have the tyranny of distance and isolation. It makes it very difficult for them to get access to services, not to mention the often patchy quality and provision of services. There are some great organisations doing some great work, but they often encounter significant workforce challenges. Simply getting allied and mental health professionals to go and live in remote parts of the state can be a significant challenge. Despite the great intentions and often the great work in some places, resources can be few and far between for people who need help at the right time. Simply getting access to services is often an enormous challenge.

I think the other key reason people have poorer outcomes in remote and very remote areas is their willingness to access those services. If you have had decades of poor service provision, you develop a habit of not seeking help. There is poor help-seeking behaviour coupled with an ethos around self-resilience and the idea that ‘we are tough and we can get through this and there is always someone else worse off than us’. As previously mentioned, there are issues around small-town confidentiality and stigma. There is a reluctance to cross a shopfront, to park your ute out in front of the health centre and go and get help for fear of being seen and noticed. People are just much less likely to reach out for help if they need to for all of those reasons. Even if they do put their hand up, they are much less able to find the help they need.

That is really why Outback Futures exists. We are about the thriving wellbeing and future hope of those remote communities in the state. We exist to help communities get better access and to ultimately change their mindset and ownership around their mental health and wellbeing outcomes. For the last 10 years we have been operating—or a little bit longer—we have been developing a model. We call it our community facilitation model. This model has been developed with our friends in the bush, so it very much reflects the values and needs of those bush communities. I will not go into the detail of everything that is in that model, but I will maybe just highlight a couple of key elements that might be interesting. I suppose that is why we have submitted to the inquiry. We think some of the learnings out of this work are not just about our future work but also learnings that we think would have value more broadly. I might just offer a couple of those to you.

The first is around our workforce model. We call it our work-in work-out model. It is really this idea that we recruit teams of dedicated health professionals to a local government area in remote areas. That team of people is allocated and dedicated to a region, and they work in couple of modes. One is a clinic mode, where they will be literally in the region on the ground providing face-to-face therapy, building trusted relationships, understanding the context. Even though all of our clinicians live on the coast, they absolutely understand what it means to drive three hours and get nowhere, turn around and go back. So they understand the context, they know what drought looks like, and they really go deep into those communities when they are in them. Then they work out of that community back on the coast somewhere, but they never leave that community in terms of their focus. Whilst they are not there, they are still working exclusively in that community. Often outreach services might leave Longreach one day and they will be in Alpha the next and Charleville the day after that. They move and their mindset moves when they move, whereas our teams stay focused on the communities they are in. That allows us to provide really high quality, consistent care for the people we are connecting with.

The second thing I would like to highlight is our extensive community engagement and connection with communities. We invest a lot of time and money in listening to and connecting with the communities we have been invited in to work with. That is important to us for a couple of reasons.

It allows us to tailor our work. We do not come with a one-size-fits-all city model that can be: 'Here it is; this is what you get.' If we listen to our communities we can actually nuance the work and the teams that we build to better reflect their needs. Equally importantly, it enables us to build capacity into those regions. We want those communities to thrive over a 10- or 20-year horizon, not to just get service delivery today. We want to build capacity for those communities to grow their own mental health and wellbeing resources, strengths and assets. We want local champions to be identified who can help reduce stigma and encourage other people to access the services that are available but also to invest into initiatives that build the general wellbeing of that community so that people are much less likely to need to get formal therapeutic help. It is our conviction that probably 80 per cent of mental health and wellbeing challenges can be met—not to be too trite—over a good cup of tea and a scone. Yes, there is always the 20 per cent who need therapeutic support, but if we can build those connections and that local capacity and community then we can reduce the need for people to necessarily access professional support.

The third thing I want to emphasise is the need for coordination and support across sectors and organisations. Our work pays a lot of attention to working with other organisations, coordinating care for people, holding people who might be in danger of dropping out of care, trying to help them navigate what is sometimes a challenging environment for people. They are the three learnings that I just wanted to pick up. You can read more detail in the submission, of course.

That leads me to finish up with the recommendations we put to the inquiry. One of them was around investing in a partnership with ourselves and Wesley Medical Research, who are here today. That was around figuring out if we could embed their Navicare model, which they have developed in Central Queensland, into our model as a way of really bolstering what we see is the critical companioning of good quality care with a whole-of-community approach. Their Navicare model is a key example of how that can work. We think it could actually bolster or work with and add a key component of evaluating the effectiveness and outcome of our work, which is still quite young in many ways.

he second recommendation was around our Head Yakka initiative, which is very much in our community development stream, which is about empowering local communities to identify and develop their own wellbeing initiatives. That initiative, the Head Yakka program, has been picked up by a number of LGAs on the back of the localised mental health grants the Premier announced about 18 months ago for all bush communities. A number of them have picked up that program and are running it. Our conviction is that that program, or programs like it, should continue to be invested in for long-term results.

**Ms Gomez:** Rural Health Connect is an online platform that links people to psychologists over video calls and phone calls where necessary. We are based in Rockhampton but we now cover all of rural Australia. We are a social enterprise, so most of the sessions done by the platform—or most all at this stage—are bulk-billed. We rely on the generosity of psychologists who work with us because the rate they receive bulk-billed is $88 versus $260 for the industry approved rate. We are finding that people want to do it because the flexibility of doing telehealth means they can be working in private practice wherever they happen to be working and just dedicate a couple of hours a week to us—or more, depending on their availability. Often it varies week to week. We can make use of any downtime they might have, and quite easily they can fit in working with us.

We have 100 psychologists on the platform currently, but we have been growing fairly significantly. We launched in 2019 and had to rebuild all of our software. That new software launched at the start of last year. We have about 40 psychologists on there now, and they keep coming along at just the right rate. We have been growing our client numbers as well. I think with things like the floods and disasters people want to help, and if you can make it really convenient and easy for them—we take on all of the admin and laborious tasks they do not want to do—it can be quite appealing. Hopefully, we can keep appealing to more and keep growing the numbers that we have.

In terms of the need, I second everything that Brent said. The need is immense in rural Australia. To finally decide to put your hand up for help and not be able to access it can really add to feelings of distress and hopelessness and can have disastrous outcomes. Being able to access that help in a timely way and feel that it is right for you is so important. Telehealth does provide a good solution. It is not a perfect solution for everyone and there are some people who need face-to-face, but if those people who are suitable for telehealth can see people that way then obviously it frees up the local practitioners for the face-to-face treatment.

Other benefits of telehealth are that if people live out of town, if they are doing multiple sessions with a psychologist, even a half-hour drive adds up to a lot out of their life. That is lost productive hours and it costs money. All of that can add to feelings of distress. I have spoken to people who were doing this, and one particular lady stands out. She was doing a 3½-hour-each-way trip into town. She said she spent the whole time analysing the impact that that day out of work has had on the family and her as she was homeschooling et cetera. Telehealth can provide a good solution for them.

It can also mean people can be matched to the psychologist who is right for them. If someone is a member of the LGBTIQ community or has an eating disorder, they might want to speak to someone who has the right training and background for them. It allows you to draw on a wide database and link people to the right psychologist for them. We have GPs on the platform now, too, to do mental health care plans, because that can be a barrier to some people seeking help, and also financial counsellors. We are looking at adding psychiatrists, too.

We have very quickly put together a couple of proposals of ways we could assist in addressing the workforce shortages amongst psychologists. One is utilising a wide database that we can assemble on telehealth that can grow to meet demand in particular areas. We found it really useful to employ project officers to work in a particular key area, which might be bushfire recovery or LGBTIQ, and really set up those referral pathways so that once they are established the referrals keep coming. It is not an ongoing cost, but it can really have a lot of benefits in just allowing people to know that a service is there and be able to link into it.

The other one is that provisional psychologists are psychologists in their final years of training. They have done a lot of study. They are fifth and sixth years, so they are very well qualified and are up with the latest research—maybe even more so than some who have been out in the workforce for quite a while—so they are very good. They need experience. It is hard for them to get it. That is a limiting factor on the number of psychologists coming through because the limited number of placements means that the universities can only take on certain numbers.

We have been in discussion with the University of Queensland, CQ University and others about utilising their provisional psychologists. They could be on the platform and maybe see people with key issues. We thought with an ageing population it could be dealing with the loneliness and isolation, maybe supporting school communities via the schools but making it accessible to the whole family. Those sorts of things could be considered with an easy step-up to registered psychologist or face-to-face when needed. The issue there is that they cannot bill through Medicare. They do not need to be paid, but there are obviously some costs mainly around supervision. They need to do an hour's supervision for every eight hours with clients or something like that. There are some costs which work out to about $25 a session. It is pretty good value and it also gives them exposure to people in rural areas and the issues they might be dealing with. It has other benefits as well.

**Mr O'ROURKE:** Can I congratulate both Outback Futures and Rural Health Connect for the absolutely wonderful work you do in regional Queensland in particular. I have heard of both of your organisations and the work you have been doing supporting people. Brent, you spoke about that community facilitation model. I would really like to drill down a little bit on that work-in work-out model that you are providing to specific communities, more from a client's perspective about timeliness of service and things like that. Are you able to talk more about that?

**Mr Sweeney:** When you say 'timeliness of service', are you asking about how long they have to wait?

**Mr O'ROURKE:** Yes, that is right, about time frames et cetera.

**Mr Sweeney:** We do have a waiting list in many of the regions we work in. It is not a long waiting list. As we activate community interest in the work, we are unable to service all of that ourselves. We do work with other organisations and refer on. Typically we would respond to any of our clients who ring for an appointment within 24 to 48 hours. We would have a response to them very quickly. We put a lot of effort into holding those clients.

Part of the challenge in remote areas is: if you have people who are very disengaged from help seeking and they do finally reach out, often there is a bit of a process to get them from that point of reaching out to really engaging and connecting with a practitioner and then building a helpful therapeutic relationship. Megan might be able to comment on this, too. I am sure she has had various experiences.

At Outback Futures we do not employ an admin person to ring and organise all of those appointments for us because of the number of times that a psychologist or a counsellor or someone has rung for an appointment and on the other end of the phone they hear, 'I have to go out. I am mustering today. I've only got five minutes. We'll have to do it another time.' If an admin person had rung, that appointment would be lost because they would say, 'Okay, let's reschedule.' Our practitioners are trained to say, 'Okay. Let's just talk for five minutes.' Half an hour or an hour later, you realise that the five-minute thing was just a nervousness or a reluctance to engage and before they know it they have actually had a counselling session.

Resource constraints aside, we respond very quickly via our telehealth or whatever it is. Someone can be down the back paddock, as has happened, on the back of their horse having what they call a friendly conversation. Our psychologists would see it absolutely as a key session, wherever they are at whatever time they can access our people. Then when we are on the ground with people we do try and see them face to face if that works as well. So you get the mix of face to face with the remote telehealth. Does that answer the question?

**Mr O'ROURKE:** Yes. You spoke about the local champion model. I know a lot of people in regional areas do say they are bulletproof and there is a stigma of being in a small town. Could you talk a little bit about that local champion model that you use?

**Mr Sweeney:** Our Head Yakka initiative was actually developed and birthed in Barcaldine when the local council came to us and said, 'We understand that mental health used to be the domain of the health and hospital system. We now understand it's impacting all of our community. We have to invest in the wellbeing of our workforce—our teachers, everybody—because if we do that, it's better for everybody. How do we own it?' That was their question: 'We can't just rely on the health and hospital system. We can't wait for the federal government to come. How do we own it?'

We developed a program called Head Yakka, which is really about bringing together local stakeholders—anybody in the local community including key local stakeholders—to evaluate their community and identify key opportunities to improve more general wellbeing. It is not a therapeutic program; it does not offer counselling services or anything like that. It empowers local people to say, 'Hey, we need to deal with this issue to improve general wellbeing.' Then we facilitate their support.

That person might put up their hand and say—and I was in Blackall three weeks ago having a conversation around this. A little old lady put her hand up and said, 'I want to run a community garden.' I have to confess that I had probably not an actual eye roll but an internal eye roll. That is because I have seen so many community gardens that are great for six weeks and then they die and it does not seem to go anywhere. Later on I had more of a conversation with her. She said, 'In our community there is an Indian and a Sri Lankan population. I want to be able to grow food, spices and whatever they need so they can cook their food and be more connected in our community.' For me, that is a totally different response. That is someone who recognises the high value of connection for a community's mental health and they are undertaking a practical initiative just to bring those people together in a small way which will hopefully be life-changing for those people who participate in it.

That program called Head Yakka is all about identifying initiatives from that basic level right through to maybe a whole-of-community initiative where the local council will be investing into mental health prevention for their workforce, for example. Local champions are those people who would put their hand up to help drive various initiatives like that.

**Ms CAMM:** Feel free, both of you, to comment, but I think it is probably more pertinent for Rural Health Connect. We saw the federal government abolish elements of the loading on bulk-billing for psychiatry services—and I will not go into the politics of who is making commitments to enhance that. You may have to take this on notice, but I am very keen to hear if there is advocacy from your workforce around a bulk-billing loading for regional and rural communities when it comes to psychology services. I am just appalled that $88 a session is considered adequate to cover a professional's time and people in our communities are already at a disadvantage for all the reasons you outlined—and I represent parts of a rural community myself. I am surprised there is not a greater priority of the federal government to bring that into line when it comes to accessibility. If you are happy to speak to it or take it on notice, what would a loading like that look like? What would help incentivise and support your workforce to access more people who require this service in regional and rural Queensland so the committee could consider that as a recommendation to be put out there towards the federal government when it comes to bulk-billing?

**Ms Gomez:** I will take part of the question on notice, which is about what the loading might look like. There is a pretty strong push to raise the bulk-billed rate across the board—that is an industry campaign that has been going for a while—to $150. Everyone is still waiting.

**Ms CAMM:** I am happy for that, but I also think on top of that there should be a loading.

**Ms Gomez:** The loading is a great idea. That was abolished for psychiatrists, but it has never existed for psychologists and I think it would be really useful. I might get back to you on the other part of your question.

**Ms CAMM:** That would be great. Thank you very much.

**CHAIR:** Can I ask a question also of Rural Health Connect? We have heard from the Australian Counselling Association, who were talking about the underutilisation of counsellors. Can you foresee that if the MBS schedule supported it there would be a greater role for counsellors in the work that your organisation does?

**Ms Gomez:** Yes, I think so. At the moment health coaches and that sort of thing are popping up and they have done far less training. Counsellors would be really good. We are dedicated to the psychologists and they have done so much training. We really value the work that they do, but there is a whole other scope of work that counsellors could do and I think that would be really good.

**Dr ROWAN:** Particularly for rural outreach services there is always the notion of having a combination of face-to-face delivery of services augmented with telehealth or other modalities. Similarly, some of the feedback we have received and through other clinicians is that having that initial face-to-face contact, augmented or supplemented with telehealth, can be really important. Do you have any suggestions or recommendations of how that could be further enhanced and coordinated, particularly doing outreach in Queensland, so as to not duplicate services but build on what exists and bring more collaboration and coordination to the combination of face-to-face and telehealth or video consultations?

**Mr Sweeney:** There has already been a lot said today about care coordination, and I think that is a key aspect. You will probably hear more about it from Wesley Medical Research in a moment. When I think of person to person, some people are happy to go straight into telehealth. Some people are probably happier on a phone even than a video. They like to be anonymous. Other people will not talk to you unless they can eyeball you and see you, so there is obviously a range of people. On the care coordination question, there is some great work being done by nurse navigators. I think nurse navigators tend to hit a higher end of complexity. They are not more generally available. We notice across the community that there is a need at lower levels of engagement just for coordination. That is a key issue.

I note that the federal budget talked about mental health coordinators being funded in each of the PHNs, so I think there is a broader recognition of the need for coordination. It needs to hit at a service level. I have not looked at the federal government idea, but I am guessing it is more at a service level of coordination rather than actually a client level of coordination. It needs to hit at all of those levels because so often you will get nuances in the bush. You might have someone who says, ‘We’ve got these people available and they’re doing great work, but they’re at capacity.’ If you go to Longreach and you speak to the CHYMS team in Longreach, they are doing fantastic work but they are at capacity. They are quite happy to refer to us on the mild to moderate end of the spectrum and we will step up to them. It is easy at a departmental or whole-of-system level to assume that those people have access and options, but when you actually drill down into it you realise there is a waiting list, or that position is not filled, or there are options over here that we have not really considered or there could be a telehealth option but the actual on-the-ground, coalface coordination of that is probably not really helpful for a lot of people. There is information out there—kind of. You can go to a website or whatever, but on the ground for an individual, what is the best way for them? I am not sure we have tackled that very well.

**Ms Gomez:** I think having someone on the ground in a complementary role would be very useful. Being able to link into the right professional over telehealth, even though they are far away, can be beneficial too and so bringing the two together would work really well.

**Dr MacMAHON:** I am really interested in this idea of bringing together care and whole-of-community activities. I wonder if you have any evaluations on how the Head Yakka program is going and what investment would be required to implement that more broadly.

**Mr Sweeney:** We do not really have great evaluations. It is very new. For example, we started working probably eight to 12 months ago in some of those regions that I mentioned earlier, so it is too early to really get great outcome evaluation data. Anecdotally, we have lots of great stories about how it is working. That is a piece of evaluation that needs to be done. In terms of cost for rollout, we put the proposal to the Premier’s COVID recovery task force, I think it was, for $75,000 a region, which was really around facilitation costs. What does it cost for us to have someone help facilitate that work? It is not a delivery project. It is not how we deliver a community garden; it is how we help the community recognise needs and facilitate and support them. How do we build a collective in a community? It is not just that there is a community garden in Blackall, for example. They wanted to restart their chamber of commerce. They wanted to do a whole values based assessment of what it means to be in that community and lead that. Someone else wanted to start a park run et cetera, so there is a whole collective action around community wellbeing.

The key role we see is actually in facilitating that, because often in local remote areas you get all sorts. David mentioned before about when two people turn up in the same room and they do not like each other. There is an amazing amount of family politics or history. Everyone knows everyone. If that person is doing it, that person is not. Whilst they have a great strength to their community at one level, they also have the shadow side of that, which is all of those things. An external facilitator that does not hold all of the expertise in terms of local area but does hold facilitation expertise is probably what it could cost. We think about $75,000 per local government area.

Whilst it is still early days, in Barcaldine where it was piloted and has been happening longer I think we are now starting to realise that after three to four years that facilitation role is not anywhere near as critical and in fact some of that needs to be wound back and for local people to run with it more freely. There, for example, we are still facilitating. Just in the last week or two a local person who runs a PT thing put their hand up and said, 'I want to run an eight-week course that's all around mental health and wellbeing and how that links to exercise. Can you help me deliver that?' So we again helped facilitate that, but it was much more driven at the local level and we are kind of coming alongside et cetera. Does that answer your question? It is about $75,000, we would say, over probably three to four years in a region and then it sort of trails off.

**Mr MOLHOEK:** I am interested to hear a little bit more about how WEBO works in terms of how you find those people who are prepared to commit to a particular community and then commute those distances on a regular basis to make that connection. What successes have you had with it? By the way, it is good to see both of you again. We caught up two months ago now on this same sort of format. I really do admire the work you are doing out there. It is good to see you today.

**Mr Sweeney:** Thank you. Many of our practitioners are part-time. They might work with us two or three days a week and they might work somewhere else. They come to us often—not always—in a part-time capacity. It sounds a little bit disrespectful perhaps at one level, but they are looking for meaningful work, which I think is part of what Megan referred to earlier.

Many of our allied health professionals right across the sector from Queensland Health to private practice are looking for meaningful work. That is why they got into that kind of job in the first place. Sometimes that gets a bit lost in the bureaucracy and the churn of private practice, with so many things you have to punch out or whatever it is. We have experienced the allied health shortage and challenges that everyone has experienced, but we have also found people willing to take a pay cut and prioritise some of their time to work with us because they get to invest back into regional communities. Many of them have been born or have grown up in a regional area. That is how people come to us.

They then are allocated to a region. We have a Blackall-Tambo team, we have a Longreach team, we have a Barcaldine team, we have a Winton team, we have a Cloncurry team et cetera, and they will then travel to those regions a number of times of year. They will go out there maybe two, three or four times a year. Whilst that does not sound like a lot, it actually is quite a lot. If you are in those remote areas it does not take long to build up a connection and build trust. Some of our team members are the longest serving allied health practitioners in those regions. They might have been there for five years. That is a long time for some people in some of those regions. They will go and spend the week there. Whilst they are doing therapy, they are also more broadly involved in the community. We would use our multidisciplinary team of practitioners to invest in community workshops or education or whatever it is. They love the fact that they are doing a broader public health kind of promotion and education role as well as their one-on-one therapy. When they are back on the coast they are doing their telehealth as the follow-up. That is kind of how it is working at the moment.

**Mrs McMAHON:** Mr Sweeney, I want to go back to an issue you talked about before, the PT and exercise. When we were up at Hervey Bay we talked to a couple of community groups that run some of these programs. One of the things they mentioned to us is that anytime you labelled something as a mental health initiative there was often reticence from community members to engage, obviously because of the stigma around it. Given the submissions we have heard around perceptions regarding mental health and stigma, particularly in rural and remote communities, how do you lead community activities? How do community members really delve into and provide these activities, which do have that underlying current of assisting mental health, without having it labelled as a mental health initiative?

**Mr Sweeney:** It is a double-edged sword. On the one hand I think you are completely right, which is why we use the term Head Yakka, for example. It is kind of not mental health; it is a different phrase. It is double-edged in my mind because mental health has become a bit of a word like 'resilience', where everyone goes, 'We're doing that again!?' You have to be careful about the overuse of it. On the other hand, we have to normalise it. Sean Dillon, the mayor of Barcaldine, gave a great analogy. He said, 'I want mental health to be like physical health. If a kid is riding down the main street and falls off his bike, everyone knows what to do. There's no shame, stigma or reluctance to respond.

They pick him up. If he's bruised or bleeding, they'll staunch the wound. If he's broken something, they will take him to hospital and set his broken arm. Wouldn't it be great if, we when we talk about mental health, we're in exactly the same place?'

I think the only way you do that is if you try and normalise that. It is a bit of a catch 22. If you say that we are never going to talk about mental health because no-one wants to talk about it, you lose the opportunity over time to normalise it. It is a bit like leading a horse to water and helping it drink and then realise that the water is actually pretty good. We have an old grazier in Blackall who would probably be 55. We will call him Bob, which is not his real name. This is a guy who has literally had a counselling session on the back of his horse while mustering down the back paddock. We asked him to present to some of our stakeholders about what it is like. He said, 'For me, I just feel like I'm ringing up and having a chat and it's just a friendly conversation.' He will describe that in a public forum. A psychologist who happened to be there at the time said, 'Actually, it was a proper psychology session.' We are trying to help someone access it in a way and then promote it in a way that actually makes sense as a normal thing to do. Hopefully that helps.

**CHAIR:** I would like to thank you both for coming along and presenting here today. The committee has been particularly interested in issues facing people in remote and regional areas. When I read your submissions I felt that you could assist our inquiry, so we are very pleased that we have been able to get you here today. Thank you for all the work that you continue to do in the communities you work in.

## GIURGIUMAN, Dr Claudia, Chief Executive Officer, Wesley Medical Research

## McGRATH, Mrs Kelly, Mental Health Care Navigator, Navicare, Wesley Medical Research

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

**Dr Giurgiuman:** Thank you so much to the Mental Health Select Committee for inviting us today. We are really pleased to be here and to have this opportunity. You have already heard enough, I think, about the suicide rates almost doubling in rural and regional Queensland and the issues around access to mental health. We have already heard that it is difficult to attract and retain quality staff, there is a lack of funding, there are those extensive waiting lists and people need to travel long distances to access mental health services.

Wesley Medical Research, in collaboration with QUT and, very importantly, local stakeholders, co-designed a bespoke model of mental health care. We applied rigorous health services and implementation science methodology and consulted over 60 stakeholders in the Bowen Basin region to begin with, from local health providers, the primary health network, council representatives and community organisations. Those stakeholders told us that help-seekers want to speak to a human being and they want to be able to walk into a building where they can speak to that human being but they do not want that building to say, ‘Come here if you have mental health issues,’ and, basically, if they can have that initial conversation with a person then they are more likely to access telehealth services as well.

As you can imagine, people who are looking for support often are not in the frame of mind to understand what is available, where they need to go, what are the eligibility criteria, how much it will cost them and all of those things, so what we have designed with the community is this new layered mental health navigation model, which has now been implemented, called Navicare. The model comprises a care navigation team, a physical hub and information services with virtual facilities. The very first Navicare hub was established late last year in the Isaac region and it has already received tremendous support. The beauty of this model is that it caters for a specific local community but it also has sufficient flexibility to adapt to other regions. It is guided by the evidence based exploration, preparation, implementation and sustainment framework. Navicare has not just received a referrals from the Isaac region; it has also received referrals from Mackay, Whitsundays, Central Highlands, Rockhampton and even New South Wales in the short time it has been operating.

The role of Wesley Medical Research, as a research institute, is to develop this model, to pilot the model—and ideally we would do so for about three years—and, importantly, to capture the right data and evaluate the effectiveness of this model and adapt it as required to fit the community needs. Ideally, we would have sufficient funding to establish Navicare across three regional Queensland communities. It would include an economic evaluation over time and then potentially transition Navicare to existing mental health service providers. You have already heard from Outback Futures, with whom we have had multiple conversations and so forth.

Piloting Navicare is critical to establishing an evidence base for scaling up and sustaining improved access to mental health services for regional Queenslanders, linking help-seekers with the support they need. I will now introduce you to Kelly McGrath, our first mental health care navigator.

**Mrs McGrath:** I would also like to thank the committee for this opportunity to highlight some of the disparities that rural and remote Queenslanders face in accessing mental health support. As a mental health care navigator, my role is to connect individuals with mental health support. When I first went into the Isaac region, I had expected that there would be a reasonably limited number of on-the-ground psychology services. I was absolutely shocked to find that there were less than I could count on one hand, and one of those only services their employee assistance program contracts, so the general public could not access it. For a local government area of more than 58,000 square kilometres, to say that this is inadequate mental health support is an understatement.

Navicare has made significant progress in overcoming some of these issues by developing critical relationships with a number of telehealth psychology providers, including some of the wonderful organisations that you have already heard from today. While those services have been invaluable in enabling Navicare to connect help-seekers with the psychological supports that they need, telehealth is not an option for some populations, and we have found that in our experience. In addition to this, recent Medicare cuts have all but eliminated bulk-billing telepsychiatry appointments, and 70 per cent of Navicare’s client base have delayed accessing mental health support because they simply cannot afford it, even at a lower rate.

Since our launch in November, the role of the mental health care navigator has expanded and evolved. Very quickly it became apparent that the social, economic and environmental factors that underpin a person's need for seeking mental health support need to be addressed concurrently with the psychological intervention. Without doing so, it is the equivalent of treating a broken leg with a bandaid—it just does not work. I have had to link clients to essential services such as emergency financial relief, legal supports, emergency housing, employment supports and community and social supports, and these key linkages are now a key feature of the role of the mental health care navigator.

Since our launch in November 2021, we have received up to 21 new referrals each month. I am case managing 51 clients. Our oldest client is 73 years old. Our youngest is four. One-third of Navicare's clients are under the age of 18 years, and half of these are presenting with self-harm or suicidal ideation.

I work at the coalface of the mental healthcare landscape and I have seen firsthand the enormous benefit that help-seekers receive when accessing the right mental health care at the right time. Our preliminary data demonstrates that these impacts are life-changing, not just on a personal level. They also have enormous potential to positively impact the community, the economy and the health system. Some of our clients have re-engaged in the workforce for the first time in decades. They have stop abusing drugs and alcohol. Some have stopped self-harming and having thoughts of suicide, which reduces the load on the health system.

The Navicare model was co-designed with the community and it is making a genuine difference. Should the funding be available to pilot the program for three years, our stringent evaluation expects to demonstrate very strong social, community and potentially large economic benefits. Mental health care navigation fills a critical gap that is imperative to giving each help-seeker the opportunity for a full recovery and the opportunity to live a happy, healthy and fulfilling life. Rural and remote Queenslanders deserve this. Thank you.

**CHAIR:** Navicare as a model is really a care coordination activity, or is it more than that?

**Mrs McGrath:** It is so many things. Yes, it is care coordination, but there is also a lot of community engagement. We are working actively to destigmatise mental health amongst the community and raise awareness of the fact that mental health supports do exist, maybe not physically on the ground, but we can provide those key linkages.

**CHAIR:** It is not just about connecting people to one-on-one treatment type services? There is a broader remit than that?

**Mrs McGrath:** Absolutely.

**CHAIR:** However, it would be fair to say, from what you have presented today, that, while it is good to be trying to navigate people towards various services and individual treatments, if they are not there it must be very challenging to help people.

**Mrs McGrath:** It absolutely has been a challenge, which is why we had to think outside the box, and we have engaged with a number of online psychology platforms. Rural Health Connect are one of our go-tos; they are on speed dial for us. In developing those relationships, they were critical in enabling Navicare to perform that role of linking help-seekers with essential supports.

**CHAIR:** If you are operating in an area like that, it is possibly the first time that someone has gone in and actually had a reasonable look at what services are available from a holistic perspective?

**Dr Giurgiuman:** That is right. When we began this work, we did not really know what the landscape looked like ourselves, so it was very interesting to be engaging in the various different stakeholders and understanding exactly what was going on and just how much support was required. We are really pleased to have the mayor of Isaac Regional Council as basically the champion for this, and she was in tears when we launched in November last year. We are really pleased that it has had this uptake and that we have the backing of the community.

**CHAIR:** Yes, Anne is an impressive woman. Services obviously work with people affected by alcohol and other drugs as well. You would have been aware of the social isolation report that was delivered in parliament previously, again identifying that need to support people and connect people into their community. Are you working in both of those spaces as well—alcohol and other drugs and social isolation?

**Mrs McGrath:** I do connect people with the alcohol and other drug supports as necessary. Also, if they identify clients who have been taken into their programs as having certain risk factors like self-harm and suicidal ideation, they will then refer to Navicare for that higher level psychological support that they feel that client needs. It is a two-way street.

**CHAIR:** How do people find Navicare?

**Dr Giurgiuman:** From what we have heard, and it is really difficult when you are implementing—

**CHAIR:** When you have someone like the mayor of Moranbah talking you up, I am sure it is not that hard, but—

**Dr Giurgiuman:** We have been told that everybody is quite excited and, in fact, we have some reference letters from various different stakeholders and we have written support from Greater Whitsundays Communities, from the Mackay mayor and from the Isaac mayor. We have visited the North Queensland PHN and had discussions with them. We have spoken to the assistant health minister. We are engaging mining communities as well, and we are funded by a corporate donor at this point for a period of time, so we are very much hoping that we will be able to extend this work.

**Dr ROWAN:** Before I ask my question, I will declare a conflict to the committee: I am a former board member of Wesley Medical Research, I continue to be a specialist physician member of Wesley Medical Research and I am an accredited visiting medical officer for the Wesley Hospital.

Congratulations on this submission. This looks really exciting—the collaboration between various organisations, mayors, as you have outlined from a local government perspective, mining and also people from Rural Health Connect and Outback Futures. What would be the specific additional funding that is needed for Navicare? I would like to get a sense, from a government perspective, of what would be of assistance to augment what already exists there. Then with regard to the evaluation framework with the Australian Centre for Health Services Innovation, AusHSI, what sort of plan is involved with the economic, social and health evaluation? When I read the submission, the applicability of what has already been achieved to date has wider implications for other geographical areas and particularly with the collaboration amongst various stakeholders. To try to give complete success to the pilot as far as the funding that is needed but also the evaluation, could you outline a little bit more about that?

**Dr Giurgiuman:** We have been saying we have funding for 12 months, but that 12 months quickly becomes six months and we would really like to be able to have Kelly in Moranbah for three years at least. The funding we are requesting is to support Kelly's role, the lease that comes with that, the travel, the telehealth services et cetera. We would also like to establish other hubs in regional Queensland and follow the same model that we have already used to define what specific needs each community has and then also establish the database. We have a database for the current hub, but we need to establish the databases for the others to be able to measure the outcomes. Indeed, the relationship with AusHSI is fantastic. They do bring expertise in health economics, implementation science, biostatistics and so forth. The idea is that, should this model be demonstrated to be successful, we could apply it in other parts even of the country. It is absolutely flexible enough to be implemented elsewhere.

**CHAIR:** Could it be implemented in urban settings as well?

**Dr Giurgiuman:** I could not see why not. Obviously that first part of the model needs to be conducted in terms of exploring the local needs and how to adapt Navicare to the individual community. Yes, it does follow that same framework.

**Ms KING:** Thank you both for being here. Kelly, you mentioned in your initial remarks that Medicare cuts to telephone psychiatry had had a big impact on these communities. Can you please elaborate and unpack that a little bit for us? What were the cuts? What was the impact?

**Mrs McGrath:** I cannot tell you the dollar value, but they have removed the bulk-billing loading for certain telepsychiatry services, particularly for one-off assessments, and two of our letters of support—one from a GP and one from a practice nurse—have highlighted how significantly that has impacted their ability to get those one-off psychiatric assessments. It has definitely been an issue. I have a number of complex cases where psychiatric evaluation has been warranted, but the individual is not at crisis point so the acute care team cannot assess them. There are no other options if you live four hours from Mackay to get that psychiatric evaluation, so it has very much impacted the community.

**Ms KING:** Are you free to share those letters of support with the committee?

**Mrs McGrath:** Absolutely. We do have a document that we would like to table at the end of this that has all of those and stories of success.

**Dr MacMAHON:** Kelly, I was hoping you could elaborate on what you were talking about in relation to referring people to other social services. To my mind, it speaks to an understanding of mental health as a social condition rather than something that is very individual. Could you talk a bit about the services you are referring people to and that kind of connection between those broader factors in mental health?

**Mrs McGrath:** Absolutely. I will preface this by saying that each individual and each individual case is different, but if someone is skipping meals and is only eating toast and cups of tea for days on end and they are living in their car, you could throw as much psychological support at them as you want and it is not going to be effective because until you take away some of those fundamental stressors, the intervention is not going to be successful. When we do an intake, we sit down and have a chat with the person and we talk about all the different things that are going on in their life. If they are unemployed, it is like, 'Okay. Can you afford groceries? Can you afford to pay your bills?' We can link them in with all these free legal services, emergency food vouchers, rural family support, and outreach programs that provide assistance in primary schools to support kids who are struggling with various things there. We link people with employment agencies and offer them skilling options. Our database does not just contain mental health services; it contains as many of those local wraparound support providers that we can find and we can access and link our clients in. That holistic approach is absolutely essential to full recovery.

**Dr MacMAHON:** Could you also elaborate on the specific risks facing people in the agricultural sector that your submission touched on?

**Mrs McGrath:** In agriculture there are a lot of stressors. They are subject to a lot of environmental disasters—floods, droughts, cyclones, bushfires, everything—so they are very much on tenterhooks at times. They can lose everything economically in the blink of an eye. That can be really stressful. We do find significantly elevated rates of suicide in the agricultural area compared to the general population. On top of those very unique stressors, they tend also to have greater access to lethal means—firearms, poisons and so on and so forth.

**Mr MOLHOEK:** It appears to be a great initiative and there are some similarities there with the previous group that we saw around some of their programs. I have a technical question. In your proposal you talk about Mitsubishi Development Pty Ltd. Are they just a mining company that have invested in the trial to support you, or is this a particular software product or infrastructure product that Navicare depends on to actually function?

**Dr Giurgiuman:** They are our corporate donor, so the former is correct. Obviously they are interested in the mining community and therefore wanted to support the mental health and wellbeing of people in that region and had provided some initial funding for us to conduct this work.

**Mr MOLHOEK:** I do not know whether you heard some of the presentations from the previous group, but they talked a little about establishing strong connections with each community. Does Navicare provide an opportunity for that or would it simply be more a broader telehealth online product?

**Dr Giurgiuman:** Navicare is physically based in the Moranbah Youth Community Centre. Those seeking support have an opportunity to speak with Kelly and have that initial conversation. Should they require telehealth services, Kelly will connect them with them. Whether it is housing or domestic violence support—whatever it might be—she is able to do that. We are physically placed in the Moranbah Youth Community Centre at this point.

**Mrs McGrath:** We also have a telehealth facility at the Moranbah Youth Community Centre for those people who do not have reliable access to internet. I find particularly the older population is very hesitant to use telehealth, but with me being an actual human who can make them a cup of tea and set up the computer for them before they go into their telehealth appointment it really bridges some of that gap and addresses some of the hesitancy that some populations feel about fully telehealth services.

**Dr ROWAN:** Claudia, I come back to the submission and the reference there from Wesley Medical Research in relation to the establishment of the COVID-19 Rapid Response Research Centre which was established in April 2020. Could you please advise whether there are any particular trends in data or research that Wesley Medical Research is seeing with respect to COVID over the last two years in the body of work that you do within Wesley Medical Research and applicability to mental health particularly but also any other trends that you are capturing?

**Dr Giurgiuman:** To explain how this sits with the COVID-19 Rapid Response Research Centre, as you all know, in March 2020 we went into lockdown and it just so happened that we were running a grant round at the time. We had five applications from across the UnitingCare hospitals for COVID-19 research. Knowing about this funding that we also had for mental health support, we ended up pulling together a number of different projects and put them under the banner of the COVID-19 Rapid Response Research Centre, including this. At the time there was modelling that indicated that suicide rates would double within 12 months. Twelve months later and today, we know that that was not the case. However, what has happened is a massive increase in people wanting to access mental health services. In fact, Lifeline, which is also part of the broader UnitingCare Queensland group, have shown that they have had a 50 per cent increase or more in people trying to access support. I think that is what the issue is. It is not so much that more people are committing suicide; it is that more people just need some help. That is what the data is showing at this point.

**Ms KING:** You talked about your ability to set people up for their telehealth appointment and make them a cup of tea. Are the telehealth consultations occurring in—'shopfront' is not the right word—a given location that people attend or are you going into their homes?

**Mrs McGrath:** We have established a telehealth hub at the Moranbah Youth Community Centre. There are a large number of other community services that run out of that area. It is very non-confronting place to go for your mental health support. People do not have to use our telehealth facility. They can access the telehealth appointments from their phone, from their laptop or from a desktop computer, but there are people who are on a limited income and they do not have data or, like I said, the elderly people in particular like to come in and they do not want to fumble around with the computer and the links, and we can help them with that.

**Ms KING:** That surrounds very flexible.

**CHAIR:** I would like to thank you for the work that you are doing and thank you for the submission and for appearing here today. It really was a fascinating submission and we have certainly heard a lot about the need for navigation, care coordination, case management. It is a very interesting model that you are rolling out there. You did not take any questions on notice. I would like to thank you for appearing.

**Mrs McGrath:** Could we table our document?

**CHAIR:** Yes, of course.

**Proceedings suspended from 1.11 am to 2.00 pm.**

**B**RUCE, Mrs Rachel, Wellbeing Support Coordinator, Mura Kosker Sorority Inc (via videoconference)

**CHAIR:** We will now resume the public hearing for the committee's inquiry into the opportunities to improve mental health outcomes for Queenslanders. I welcome Mrs Rachel Bruce. Rachel, you are welcome to make an opening statement and then we will go to the committee for questions.

**Mrs Bruce:** I would like to acknowledge the traditional owners of the lands on which we are having this meeting and pay my respects to elders past, present and emerging.

**CHAIR:** Did you want to make an opening statement or are you happy to go straight to questions.

**Mrs Bruce:** I am happy to go straight to questions.

**CHAIR:** Could you start by giving us an overview of your service, where you are located, who you serve and the issues facing people with mental health issues who access and obtain services in your neck of the woods?

**Mrs Bruce:** The organisation that I work for, Mura Kosker Sorority, was established approximately 30 years ago. The service was about advocating for women who are going through issues. It has changed over the years to now having different programs within the organisation. The services that we have now in the organisation include the Mura Buai Family Wellbeing Service, the family and domestic violence service, the children and family service, the older people action plan service and the family participation program. The area that we cover is Thursday Island and the inner islands of Horn and Hammond, and then the outer islands. In the Torres Strait we go up to the eastern, western and top western islands, and the central islands as well. We cover the 11 communities on the outer islands. Our workforce is based on Thursday Island so service delivery entails travelling by plane to the outer islands.

**CHAIR:** What sort of staff do you employ?

**Mrs Bruce:** We have case workers, we have support workers and a few of our staff members have now completed the counselling course. We have the counselling program and DV counsellors as well. I am an accredited mental health social worker. My role is to oversee the programs within the organisation.

**CHAIR:** Let us start with the outer islands. Do you service them on a periodic basis by running clinics or do you go out to see particular people? Do you do group programs? How does it work?

**Mrs Bruce:** We have clients on the outer islands. We go out and do home visits and see clients. We deliver programs out there like social and emotional wellbeing programs, talking about relationships and family support as well. Our programs range various topics and we do sessions with the community. We do one-on-one support as well. The Mura Buai Family Wellbeing Service does financial support with families, parenting support and also home routines for the children. It is whole-of-family support.

**CHAIR:** How long would someone be in that program typically? Is it ongoing or is it time limited?

**Mrs Bruce:** Once we create a routine for the family and we can see that the family is getting on well or things have changed within the household, the client exits the program. That is the thing: we work with the family and once we can see that changes are happening and the family is okay to exit the program, we do the exit out of the program for the client.

**CHAIR:** How do people enter that program? Are they identified in some way or referred?

**Mrs Bruce:** We get referrals from QPS and from Education Queensland, as well as from the other services on the island. Lately, we have been getting a lot of self-referrals from individuals in the community. We are finding a shift from the normal referral from services to families seeking support for themselves, which is a good thing for us in terms of families recognising the organisation and that we are here to help them. The majority of our referrals are from the QPS in terms of the domestic violence space. As I said, we get referrals from other services as well. We work closely with the school in terms of delivering programs at the school, especially for the high school kids. We have a good working relationship with the various services as well.

**CHAIR:** That is the school on the main island?

**Mrs Bruce:** Yes, Tagai Secondary College.

**Dr ROWAN:** Thanks very much for the presentation and submission. There was mention of drug and alcohol preventive education. In the communities that you work across, what are you seeing in relation to alcohol and drug issues? What are your thoughts around preventive education programs or strategies or even clinical services that are needed to assist with dealing with those particular issues?

**Mrs Bruce:** Alcohol and drugs are a big issue up here in the Torres Strait. In terms of the referrals that are coming through, as I said, they are mainly through the QPS. The referrals that come through are in relation to domestic violence, which is the end result of alcohol and drug abuse within the community. It is a big issue. The complexity of it is that it affects the whole family. You can see the domino effect of drugs and alcohol with mum and dad fighting and then the police getting involved, but then you have the kids. Because you have extended family living in one household, it impacts the family as a whole. It is a big problem.

In terms of us going into the community and delivering education sessions with families, it is around anger management and it is around family. We try to tap into the cultural context as well, of the whole of family and the essence of family, trying to look at how we bring our cultural structure back into family where there is a dysfunction within the family and a breakdown in the family. You are not tapping into one issue; there is a complexity of issues that surround drugs and alcohol within the community, affecting families as well.

**Dr ROWAN:** With alcohol and drug issues, is alcohol still predominantly the problem substance? If not, when it comes to drugs is it amphetamines or other substances? I am trying to get a sense of what is happening in the communities there.

**Mrs Bruce:** Alcohol is the main problem. The main drug up here is marijuana, but alcohol is first and foremost in terms of issues that are impacting families. You have varying results with alcohol affecting family and then you have results from alcohol and marijuana affecting families. Alcohol is the main problem up here.

**CHAIR:** Does your organisation find itself in the situation where you have people with more complex mental health or alcohol and drug issues than you can manage locally in situ and you have to refer on to places such as Cairns?

**Mrs Bruce:** Our referral pathway is through the Queensland Health ATOD team. With social and emotional wellbeing in terms of the complex issues identified with family, we have a referral pathway to the services up here with the mental health team. In regards to the complexity of family issues, we do a referral pathway to the social and emotional wellbeing team up here as well. We have a good referral pathway in terms of supporting families to access other services.

**Dr MacMAHON:** Could you outline the costs associated with running your service and where you get your funding from?

**Mrs Bruce:** Our main funding is through the Department of Children, Youth Justice and Multicultural Affairs. In terms of the costings, I apologise that my CEO is not here today. She would be in a better position to answer. I can give an overview of the costs associated. We have to fly to the outer islands and the costs of flights up here are ridiculous. We fly to the outer islands and stay there for two to three days and then fly back. We have to catch a helicopter to one of the islands. The cost of that is really high. When you look at the geographical area that we cover, in the first instance we have to ensure that we get the permission to go to the island from the local council. There are costs associated with that because you have to catch a nine-seater plane. Then you have inclement weather at times. There are all these associated things around that. The cost itself is really high. If you want the figures around that, I am more than happy to give you the figure later on when I can talk to my CEO.

**Dr MacMAHON:** That would be great. Could you also elaborate on the support that you offer specifically for children? You mentioned that you work with the school and I think you have run playgroups as well. Can you elaborate on the importance of the work that you do directly with children?

**Mrs Bruce:** Our work at Mura is preventive and intervention so we look at working with families and children from a very young age. The work that we do is skills and development and also looking at our cultural aspect as well in the program. We have elders come in and talk to the children. We deliver PPP and parents have been engaging with that. Our workers find that they are quite receptive to the program.

They attend sessions and I run the Positive Parenting Program. That is well received. We have play sessions for the children. When there is a community event we run activities for the children as well as for the adults. We ensure that the kids are part of the whole event and they engage with the elders and adults as well.

In terms of starting from a younger age, we are working at the school with the high school kids but also the younger siblings of the family. If we get a referral for the family, we work with the young ones as well around bullying and things like that. There is a whole range of programs so we can sit down and yarn with the kids about development things, bullying and also changes. We talk to the young people about that.

When a referral comes in, we do not only focus on just the immediate person on the referral, but we work with the whole family in a holistic way and provide support for the whole family. That is working with the young people and getting the kids involved with different programs and the family as a whole.

**Mrs McMAHON:** I am interested to get an understanding of the perceptions and community stigma around mental health. It is something we are hearing quite regularly on this committee. Certainly in regional and remote communities there is another layer of stigma that comes with living in small communities. From your perspective, with a cultural lens over the top of it, how do you find the public perception or stigma around mental health and those barriers that impede access to programs which are either solely focused on mental health or that provide mental health support, and the community's willingness to engage a service that is funded with a primary purpose of improving mental health?

**Mrs Bruce:** It is still a taboo topic in some communities. From my perspective, I can see a shift in the dialogue with families and also with community. There is still that issue of the actual wording of mental health. From our point of view within the organisation, how we talk to families, how we go out in community, it is around social and emotional wellbeing and the families are quite comfortable with that. The wording we use when we talk and have a yarn with families and community is important. We are trying to break down that barrier to families coming forward and talking about mental health. Also from a cultural perspective when we have a yarn we bring the essence of family. Family to us is very important. We are trying to look at how we have the dialogue with families and bring in words like 'social and emotional wellbeing'. That family member needs our support, so the dialogue is important. The wording is important when we talk to families and communities.

There is a shift more towards being open and receptive of yarning around mental health, but we still have to look at the words we use and also having the conversation with our elders around mental health. I think it is fear and not really understanding about mental health. We try to break that down so that community understands mental health and the wording we use and also the importance of talking about what supports are in place for their loved one affected by mental health.

In saying that, the wording we use and also what support structures are in place—you can see that when community are receptive to that, it is like they say, 'Okay, I understand now what you're talking about. I know there is support out there for my son or my daughter or family member.' That kind of breaks it down so that communities feel a bit more okay. There are still some in the community who find it difficult to talk about mental health.

We are chipping away slowly and we are getting there. We will get there eventually. It is just a matter of making sure people understand what is mental health and how we can support our loved ones affected by mental illness.

**Mrs McMAHON:** Could you talk to us briefly about peer supports and peer networks that you might have within your community that help those conversations, or issues or barriers you have in identifying or developing peers within the mental health space in your community?

**Mrs Bruce:** In terms of peers, the support structure is mainly family members, a cousin or another aunty or uncle. They are the main support for the family and the family feel quite comfortable with that—to have another family member being the support person or the one affected by mental health. It is far easier to have that conversation with—I would not say a peer. It is more about saying, 'Okay, we can get this cousin involved and they can have the yarn with you.' It is easier to relay the message back to them and they understand what they are talking about as well.

The additional support structure for families is extended family. The whole notion of extended family—that is how we use the support for family members as well.

**CHAIR:** Can I ask you where you did your social work training?

**Mrs Bruce:** I did it in Brisbane at UQ.

**CHAIR:** The reason I am interested is one of the big issues we have heard of frequently in this inquiry is the difficulty in attracting and retaining staff. It becomes more difficult as you move further away from Brisbane, so I imagine it is pretty tricky in TI. In terms of young people who might be aspiring to work in the health workforce, whether it is mental health or otherwise, how difficult or challenging is it for young people in Torres Strait to follow that pathway and become a health worker of any particular type?

**Mrs Bruce:** I am one for supporting young people in furthering their education. I am a big advocate for that. From my experience, I had to get off the island to go and further my education and get my degree in social work. I am back on TI now. In talking to young people around the feel of health worker, social worker or psychology, it is about having that conversation and encouraging the young people. Different people come up to Thursday Island who do not understand the culture up here. I would say, 'This is an opportune time for you young people to go and get this piece of paper, so to speak.'

Within the organisation it is about the staff training as well and, as I said earlier, about staff getting their diploma in counselling. As we go to the outer islands we have the conversation around career pathways. There is a lot who want to go on that pathway to the health field. It is about just encouraging them. I use myself as an example to say, 'You can get your degree. You can do anything you want.' I think it is about having the conversation. Also when I have come back and the young people have asked, 'Where have you been? What have you done?', I explain to them and they often ask, 'Is it hard?' I say, 'If you apply yourself, you can do anything.'

The hardest thing is knowing that when the young people leave the island there is support in place for them, whether it be in Cairns, Brisbane or wherever they go to uni. I know some of them have said, 'It's too far away from home,' and they get homesick and all they want to do is come back home. We should encourage the support structure within the universities—and I know it is there—to ensure the students see it through and get their degree. A lot of them have said it is too far away from TI and it is too long when you tell them it is a four-year degree. It is about encouraging them and having the conversation with them.

**Dr MacMAHON:** I want to ask if you offer families any financial support like food vouchers or any families who are in particular need.

**Mrs Bruce:** We have the emergency relief fund through the Salvation Army. We provide the supports through that. Family would come in and ask for some support and then we would talk to the Salvation Army. We have the emergency relief fund as well. We did have the brokerage during COVID for the family and domestic violence program for supporting mums to come off the island because of domestic violence.

Another thing in terms of financial support for families is when you look at the outer islands, if there is domestic violence, they have to wait for the police to go out. There is not a shelter or anywhere they can go to seek refuge, apart from the health centre. There is a whole range of monetary processes of getting a flight from the outer island which, as I said before, is quite expensive, getting them to Thursday Island, going to the women's shelter—and there is our relationship with DVConnect as well. There are those monetary aspects. That was the brokerage funding we got during the COVID period for mums and children coming in from the outer island. We have the ERF, the emergency relief fund, as well.

**Ms KING:** What is the pathway for someone in your community whose mental health issues are severe enough that you cannot work with them or that you cannot give them all the support that they need? What happens to those people?

**Mrs Bruce:** My understanding in terms of those complex needs is a referral pathway to a mental health team. I know from my work with mental health the referral pathway is to the service in Cairns. The referral pathway for us is the complex client is referred on to the mental health team, and, due to the severity of it, the mental health team would do the referral down to Cairns.

**Ms KING:** I am reflecting on your evidence about helicopters and very expensive flights. I am wondering what that means for people in terms of timely access to acute care if that is what they need. Does it mean there are extra waits? Is it that much more difficult?

**Mrs Bruce:** It is difficult. There is that wait but there is also the wait in terms of the police going out to the island if it is a very severe case where the client is in need. Then there is the wait for the police getting there and the flight back to Thursday Island. There is that. It is not straightforward. It is not a case of you hopping in a car and going around to the next suburb. It is a waiting game: waiting for the flight, waiting for the plane to get there and then come back from Horn Island to Thursday Island and then, if need be, down to Cairns.

**CHAIR:** Thank you very much for taking time out of your busy day to present to us this afternoon. Part of the reason we have asked a few different organisations from your neck of the woods to present is because the member for Cook, Cynthia Lui, approached the committee and asked if we would make sure that people from TI were represented in the inquiry. We really do appreciate that. We wish we had the time and the capacity to get up to TI ourselves—it is a beautiful part of the world—and visit. The next best thing for us is to hear from you in person and some of the challenges you face. On behalf of the committee, I would like to thank you for all the work that you and your organisation do to support the people of TI, particularly those affected by mental health issues and alcohol and other drug issues. Thank you very much.

**Mrs Bruce:** Thank you very much for allowing me to take part in this. Hopefully one day you will come up to Thursday Island and we will show you around.

**CHAIR:** I would love to.

## PRICE, Ms Karen, Chief Executive Officer, Cooktown District Community Centre (via videoconference)

**CHAIR:** I invite you to make a brief opening statement if you so choose and then we will go to the committee for questions.

**Ms Price:** Thank you for having me today. I will give you a bit of a breakdown on what the community centre here does. We tend to think of ourselves as cradle to the grave. We provide everything from intensive support playgroups through the gamut of family support, youth engagement strategies, youth AOD through to domestic violence and then finally to the sixties program. We have pretty much everybody covered except that generalist space (inaudible) I have to say that I have probably never worked for any other service but for this one, so we are very much in a grow-your-own sort of space. We are very well regarded in our patch. We service Hope Vale about 50 kilometres to the north, Wujal Wujal to the south and out to Laura. I guess because of the travel that we do and the way that we engage, it often puts us in a precarious space in terms of our scope of practice in that we become a catch-all for the way referrals are coming through. Quite often we are teetering on the brink with mental health because there are not a great deal of options to refer on in that mental health space. We have Queensland Health here with the mental health and ATODS program. The Royal Flying Doctor Service also has a mental health service here. The risk for organisations such as ours is that we tend to end up with staff who perhaps end up taking on more with a risk of moving out of the scope of practice purely because there is no opportunity to move things on. That is us in a nutshell.

Over the last couple of years, particularly through COVID, we are starting to see the increased prevalence of mental health with young people especially. We tend to engage a lot within the children and young person space. Aspects that will probably help to improve it in the region from a mental health perspective would be to see psychologists based within our schools. I know that it will cost a lot. At the Cooktown State School level they are moving to try to get there, but obviously there is a shortage—there is a shortage everywhere—so it does come back to us. Quite often we will have referrals who are in a behavioural space but there will be a lot of underlying issues.

One of the things also is the prevalence of domestic violence with the population that we are dealing with. I suppose again in that mental health space one of the things we would like to see is the ability for young people to self-refer, whether that is under Gillick competence arrangements or whatever, in order to find some social and emotional support without requiring that parental consent, knowing that some of the things they want to talk about are going to have implications for their home life. We need to see some improved assessment tools around our staff, particularly in the counselling space, but again in the deployment of counselling space to make some assessments around their own scope.

I will finish with the fact that in the social determinant space at the moment we are seeing an increased prevalence of mental health—maybe not at the critically pointy end, but certainly there are people with so many underlying factors within that space. I am sure you have been informed over and over that the housing pressures being experienced in the city at the moment are spreading out very much into the regional and remote areas as well with cost-of-living pressures out here, and again all of this is overlying quite a significant inequity of access to health, education et cetera. That is probably where I will leave my part of the presentation.

**CHAIR:** You talked about your staff—I assume they are staff rather than volunteers—working beyond their scope of practice. Are these social workers, psychologists, peer support workers?

**Ms Price:** On the staff at the moment we have one social worker. We have around 18 staff at the moment. Being in a regional setting, from what I can make of it we are quite a unique little brand of neighbourhood centre that has domestic and family violence, and that family support works closely with child safety as well. So we are in a bit of a messy space of not being a true neighbourhood centre, welcome to everybody, to where we have these pointy-ended services. The staff who are working in them are predominantly diploma based. As I say, one of our counsellors has a degree in social work and has worked in the mental health field. One currently holds a position as counsellor for perpetrators of domestic violence. The rest of our staff are either working with a diploma in counselling or a certificate 4 in early childhood studies, those sorts of things around it, and being mentored to provide additional supports. A little bit of knowledge is a dangerous thing, and we are always cognisant of the fact that wanting to help people can step over into quite a risky space.

**Mr MOLHOEK:** I am interested to know what other services you have in Cooktown, whether allied health services, GPs or the local hospital, that provide support around mental health and what supports you have around chronic mental health where there might be incidents or events that need more significant intervention.

**Ms Price:** Absolutely. I will acknowledge at this point too that I am on the board of the Torres and Cape Hospital and Health Service, so I am very familiar with the service there, which has been largely impacted, I have to say, by COVID. The standing order of the HEOC here in this region has resulted in the diminishment of those allied health services for quite a while. We have just today dropped down to tier 3 in terms of the COVID response, so we will start to see a return to BAU fairly soon, I am hoping. We have a mental health and ATODS team, but they are quite under the pump in terms of the referrals that come in to them. Again it is that flow-down of what others are doing and that criticality before it is, 'The not for profits can deal with this cohort but with some supports from mental health.'

We have another couple of not for profits here in town as well. Gungarde, whom I believe you were meeting with prior to myself, is a community-controlled Indigenous organisation that has family wellbeing programs that run there. As well, Apunipima is the community-controlled health organisation operating out of both Wujal and Hope Vale, and they have capacity in there as well around that mental health space. Additionally, we have Life Without Barriers that operates a women's shelter here in town, and on occasion we have the delivery of a few other programs from Strong Mob which are social and emotional rather than specifically mental health programs that operate down into Wujal and Hope Vale. For everybody at the hearing here today, we are dealing with a population overall of about 5,000. Of that population, probably about 40 per cent would be Indigenous.

**Mr MOLHOEK:** I have been to Cooktown only once. It is a magnificent spot. I was up there with Jeff Seeney and our cabinet about 10 years ago. One of my favourite photographs is us on the banks of the Endeavour River, which is incredible. I think context is always helpful. How long would it take someone to drive to Cairns and how long is the flight time from Cooktown to Cairns, which is the nearest major health hub, isn't it?

**Ms Price:** Absolutely. It is a four-hour drive, and if you do it faster than that you cannot do it legally. Essentially, it is a 45-minute flight, but with the wait time on both ends and the rest of it, a lot of us do drive and it is that convenience of having a vehicle. Because Cairns is a long, skinny, drawn-out place in itself, most people do tend to drive. While we are on that subject, in terms of our geographic footprint of working with the communities that we work with, it is around about 45 minutes to drive to Hope Vale, 45 minutes on a good day, and it is about an hour and a quarter to drive down to Wujal. In terms of our outreach services, we service those communities every week. It starts to consume big chunks of time just for staff to be in vehicles to do that travel. We are remote, but you have been here. It is also a pretty idyllic little place, and because of that tourism side of it, it probably has more mainstream services and more of a country town, tourist destination feeling than most remote places.

**Ms KING:** You mentioned that one of your counsellors provides counselling services to DV perpetrators.

**Ms Price:** That is right, yes. One of our programs is a specialist program. Currently I think it is based in three sites across Queensland: on Thursday Island, Mura Kosker has the contract; then out of Murgon operating under Cherbourg. It is an Indigenous domestic violence family violence program that is aimed at having a counsellor, and again I use that term advisedly. It is very much around casework, support, referral and advice as opposed to clinical counselling as such. One of the staff works with victims, one of the staff works with child witnesses and the other one works with perpetrators. In that perpetrator space again they are not so much doing that Relationships Australia type one-on-one counselling but working with the justice group space to help communities with the men's groups out there to help those perpetrators identify the damage they are doing within their families, to acknowledge the cyclical nature of family violence as victims themselves, most likely as part of that ongoing issue with parenting within the communities, and to work with groups of men about them having support networks in order to achieve some of the changes.

Again, we will work with Probation and Parole, for instance, with men coming out of prison and coming back into the communities, to provide them with a range of supports, tools, advice et cetera all with the intent of keeping families well. It constantly creeps into that mental health space of needing those additional pointy-ended mental health supports. Again, it is quite critical that it is really quite limited.

**Ms KING:** I suppose that was where my question was going. Of all of the groups that have come before us, there have been very few that have provided information on perpetrator focused services. Given everything we have heard about the enormous coexistence of domestic and family violence and mental ill health, it was very interesting to hear that you are providing those services in your community. Thank you for sharing the details about them.

**Ms Price:** I will add one more proviso to that. We have been running this program now for nine years and we are currently on our seventh person in the role. That person is still within their probationary period. The seven have all been men. Of the seven men who have worked within that role, a couple of them have had mental health type qualifications in social work or been mental health qualified practising nurses. In that time only one of them has actually been an Indigenous man, which would be the preference obviously of the funding body and of ourselves. It speaks for itself: seven in nine years. It is a very difficult space to fill and it is a critically hard area for people to work in.

**Dr ROWAN:** Thank you very much for your submission today. I want to ask about the outreach from alcohol, tobacco and other drug services and mental health that comes in there. Does the outreach come via Cairns and is there a visiting psychiatrist?

**Ms Price:** I did notice amongst the submissions that there is a written submission from YETI, Youth Empowered Towards Independence. The submission came from Genevieve Sinclair in Cairns. She mentions four different programs within her submission. The final one is called RADIO—goodness knows who dreamt this name up—which stands for Remote Alcohol and Drug Interventions and Outcomes. It is an interesting model. It is funded by the North Queensland Primary Health Network, auspiced through YETI.

We have a clinical line manager who supports a number of staff right across Thursday Island, Weipa, Bamaga and here in Cooktown. Gungarde has a young woman working there. Our staff member is a male who is highly qualified, but not in that area. He has a master's in philosophy. He is only a young man. He has been doing quite phenomenal work in terms of supporting young people to make better decisions. I am not sure if I am supposed to name people, but James Edney is based with YETI in Cairns and does a magnificent job of supporting young youth workers across the Torres and cape to provide those supports. We provide line management here and he provides that clinical line management. It seems to be a model that is working well. They bring the workers together a couple of times a year to discuss different strategies that they are working with, but they come from all sorts of backgrounds. Most of them are unqualified except for this passion that they have to work with young people and to try to turn them around in that space. It is an interesting program. They tend to ally themselves to the dovetail-type model and it sits there very firmly under YETI.

**Dr ROWAN:** With the provision of services at, say, Cooktown hospital, if they are via the hospital and health service, how do they tie in with what is happening at the community centre? If the communication and coordination of new services or new outreach is to be established, or additional telehealth supports, how does that or the discussions occur as far as planning of service provision goes?

**Ms Price:** I would say it could use some improvement. I would also say that probably pre-2020 it was working better. Again, I emphasise that I think COVID has really made it difficult to have been continuing with many of our services at all. Essentially it tends to be a one-way street, which is us referring out mental health patients or those with AOD issues. We just do not have the capacity to be able to deal with them because of the staffing that we have. Certainly at an interagency level, they are signatories to our interagency and we are as well. We are aware of what we are doing. We have great working relationships with them in terms of that ability to pick up the phone, but the integration across that referral space could probably use some additional help.

That is why I said in my opening comments that one of the things that would probably be of huge assistance, if anything was to come out of this, is perhaps at a statewide level the development of tools that might be better suited to these sorts of organisations where we really are at that much lower end. I think the neighbourhood centres and community centres tend to do a lot of heavy lifting but it is at a less critical stage. It is that ability to be able to decide effectively where you start to move into risky space. One of the issues for us, for instance, with the social worker—who again has come across from Queensland Health and is working in the perpetrator space—is that he tends to be using Queensland Health type assessment tools, but none of the rest of our staff are actually qualified to use those. So we are working on tick-and-flick type actual responses as opposed to observational data where they may be able to make better assessments.

**CHAIR:** Karen, you talk about the heavy lifting that you are doing at the lower end of the spectrum. Do you feel that the work that you do stops people progressing to developing more serious mental illnesses and ending up in hospital?

**Ms Price:** Absolutely. If anything, we have some fabulous partnerships in place too. Not all of our programs are funded by the state or federal governments—ultimately they are, but it is through different avenues. We have an amazing program that we have had running since Cyclone Ita in 2014, in partnership with the Salvation Army. I had given back our emergency relief to the department on the basis that I just did not want to be part of that $15,000 or $20,000 a year of handouts. What we ended up with is a far better model, working with the Salvation Army through their Doorways program. I think it is about being able to support people at that level where they have a time-based type crisis that we can assist with. In the same way we have partnerships with Good Shepherd Microfinance to assist people with things like NILs loans and whatnot. Whether it is financial stress or requiring supports and advocacy for housing and things like that, we can definitely provide those supports that are keeping the wolf from people's doors and so on.

**Dr MacMAHON:** Following on from that, could you elaborate on some of the social determinants of health that you mentioned earlier around housing and cost of living? How is that manifest on the ground and what broader strategies would you like to see in place to address those?

**Ms Price:** Again in the collaborative space, at the moment there is quite a body of work being done between the Cook Shire Council and Queensland Health around the development of a housing site here. My understanding is that at the moment the department of housing in Cooktown has 184 individual applications for housing. This is in a town, across those three communities, of about 5,000 to 6,000 people. There are 184 applications for social housing. We know of people living in cars. We know of a woman living with a baby in a car at the moment. It is becoming quite dire.

The issue is that there has not been that appreciation gain in the value of housing up here unlike what has happened in the metro and larger regional areas. People are less likely to want to invest. Even though the rental returns are quite astronomical, they do not tend to invest because they are not seeing the appreciation. We have this breaking point at the moment where you are not seeing private investment despite the fact that the returns are going to be fairly good in the short term through rental. Looking at other models, currently, as I say, Queensland Health and the Cook Shire Council are in conversations with the local government insurance agencies around a large-scale investment into government housing, hoping that that will free up some of the private rentals back into the affordable rental market. That is probably No. 1.

Obviously again at a regional level the cost of living is quite high. The local supermarkets are much more expensive than your average Woolworths and Coles. We are also seeing increases obviously in things like power bills, even though I think they have been compensated reasonably well through COVID. Those kinds of pressures mount up and mount up for people. As a determinant of health, given that we are talking about mental health at the moment, those pressures and strains lead hugely to why we see people we would not normally see turning up for assistance—maybe turning up for some of the programs in the community development activities that we run but not turning up looking for that sort of support and assistance.

**CHAIR:** Karen, thank you for the work that you are doing in the community of Cooktown and surrounds. We appreciate you taking the time to be here this afternoon. It will certainly help the committee form its report going forward. Thank you very much for being here.

**BRANJERDPORN, Dr Grace, Lead Clinician, Mental Health, Alcohol and Other Drugs, Mater Health—Perinatal Mental Health**

**FARMER, Mrs Rani, Operations Manager, Peach Tree**

**HENRY, Dr Majella, General Practitioner, Parent Education Support, Mater Health—Perinatal Mental Health**

**KISSANE, Mrs Viv, Founder and Chief Executive Officer, Peach Tree**

**McGAHAN, Mr Greg, Senior Manager, Young Adult and Mental Health Services, Mater Health—Perinatal Mental Health**

**CHAIR:** I now welcome our next group of witnesses. We appreciate you all coming in this afternoon. I ask each organisation to make a brief opening statement and then we will go to the committee for questions. Who would like to go first?

**Mr McGahan:** We will go first. Thank you for the opportunity to provide information to the committee today. Mater would like to acknowledge the traditional owners of the land on which we meet today and pay our respects to elders past, present and emerging. We would also like to acknowledge our colleagues from Peach Tree and the important role of the peer workforce in the perinatal mental health continuum of care. We would also like to thank various people and groups that have supported the submission we have provided to the committee, including a person with lived experience of perinatal mental illness and the sister of a Queensland mother who recently died by suicide.

It is important that we bear in mind today as we discuss perinatal mental health that, while we often talk about perinatal mental health in the context of the mother or the primary carer, we should always consider the infant's mental health and detachment as that dyad is the focus of care. Mater has made three submissions to the select committee around young people's mental health, the mental health of people with autism and intellectual disability—and I believe my colleague Dr Cathy Franklin was here yesterday—and perinatal mental health as we have specialist services and expertise in these areas. Mater Mothers' is Australia's largest birthing hospital and Mater has maternity services at other locations across Queensland. Combined, Mater supports Queensland mothers to deliver over 12,000 babies per year.

While experiences of mental illness and psychological distress during the perinatal period vary widely, perinatal mental ill health is relatively common. Approximately one in five women will experience postnatal depression and anxiety within six months of the birth of their child. One in 10 women will experience clinically significant symptoms of depression during pregnancy. While perinatal depression and anxiety are most common presentations, women may also experience a range of other mental health conditions. Research tells us that one to two in every 1,000 new mothers will experience a postnatal psychosis.

Each year nearly 10,000 Queensland women require primary care for mental issues. Nearly 3,000 require specialist psychiatric treatment and over 200 require hospitalisation. It is important to remember too that those hospitalisations predominantly happen in adult mental health facilities where the baby cannot be admitted with a mother.

Every year almost 1,000 mothers with children under 12 months of age will present to Queensland emergency services in a suicidal crisis. Despite the prevalence of these presentations, mental health conditions during the perinatal period often go undetected an untreated. If untreated, perinatal mental health issues can result in long-term emotional and social wellbeing impacts for the parent, child and families and, in some cases, perinatal mental illness can result in maternal suicide or infant death. Maternal suicide is the leading cause of death for women in the perinatal period.

The recommended ratio for specialist mother-baby beds is one bed per 1,500 to 1,600 births. Using this formula, Queensland should provide between 38 to 40 dedicated beds for mothers and babies in Queensland. There are currently four mother-baby beds in Queensland, equating to one bed per 15,000 births. By comparison, in Victoria there are 33 operational beds in six public units. This equates to one bed to every 2,300 births.

The Productivity Commission in its report on mental health highlighted the potential for significant economic benefits associated with investing in support for new parents in the perinatal period. The economic impacts specifically for Queenslanders is estimated at $417 million through the first three years of life.

Mater has been shaping services to respond to unmet community needs for over a century. As Australia's largest birthing hospital, we know these parents and we hear their stories. We have been working to develop services for many years, and most recently have undertaken to build a dedicated perinatal mental health facility called Catherine's House, which will be completed by the end of the year. Catherine's House will see some existing services like our longstanding parent aid unit, which is a community facing volunteer program, come into the facility. Our parent support centre, where Dr Henry works, will come into the facility as well. It has GPs, lactation consultants and child health, psychology and other allied health professionals. Our perinatal psychiatry and psychology services, which work across all of our maternity programs, will come into the program as well. Currently, they see about 30 mothers and babies a week. We will establish some private perinatal mental health consulting suites so that consumers can have some choice in treatment. Most importantly, Catherine's House will deliver eight public specialist perinatal mental health beds. We will also add two beds to that bed stock which will significantly improve the situation for Queensland. Combined, Catherine's House will provide a broad spectrum of care, ensure consumers have choice and ensure that care is aligned with their acuity. These programs will be integrated and have a focus on research and workforce development. It will be the first of its kind in Queensland and unique in Australia.

Mater has worked closely with the Queensland Centre for Perinatal and Infant Mental Health and the Mental Health, Alcohol and Other Drugs branch in planning the integrated model, and particularly around identifying the bed platforms required. Mater is awaiting a decision on operational funding of $11.9 million per year to run the program and a one-off capital investment of $7 million. Mater has raised over $17 million towards the build from generous donors through the Mater Foundation, which has significantly offset the cost of the build and represents value for Queensland Health in terms of capital investment.

To finish, I reiterate the recommendations we put forward in our submission to the committee. We hope that the Mental Health Select Committee makes a finding that there is a significant deficit in available and appropriate perinatal health care in Queensland and that there is urgent investment needed in perinatal mental health. Queensland needs an adequate baseline of acute mother-baby beds. Queensland needs an appropriate level of integrated responsive outpatient mental health support for mothers, infants and families during the perinatal period. The Queensland government should support the development of a comprehensive and statewide approach to perinatal mental health. Mater can assist in the delivery of these services across the state.

**CHAIR:** Thank you. Viv, did you want to make an opening statement?

**Mrs Kissane:** Good afternoon everyone. I also acknowledge the traditional owners of the land on which we gather and pay our respects to elders past, present and emerging.

We are very glad to appear here beside our esteemed colleagues from the Mater and thank the committee for this opportunity to provide more information about Peach Tree and our work in the perinatal mental health sector. Peach Tree is a community-based perinatal mental health service that provides peer-led support in the Brisbane north, Brisbane south and Moreton Bay areas.

Perinatal mental illness has had a profound impact on me individually and on my family after I became significantly unwell after the birth of my third child and also after losing an immediate family member to maternal suicide after she chose to take her life after the birth of her fourth baby. I founded Peach Tree in 2011. In our 10 years we have continued to put our lived experience at the core and at the heart of everything we do. We started as two women driving around in our cars with beanbags and toys in our boots, looking for free venues to meet with other mothers. We are now an organisation that is accredited under the national mental health standards. We have won achievement awards. We are recognised for championing the lived experience workforce. Most importantly, we are a vital part of service provision along the perinatal mental health continuum of care and we have helped hundreds of local Brisbane families.

Peach Tree works from a village building approach—using our lived experience to destigmatise, normalise and validate experiences of emotional, social and mental health challenges that can and do occur around the time of pregnancy, birth and the early years beyond. Although we are a perinatal mental health service we do extend our offerings to parents and carers of children up until the age of five, in recognition that the first 2,000 days is a significant period to impact the trajectory of a child's life.

We offer targeted mental health peer support groups for pregnant women and for mothers, fathers and caregivers. We run parenting programs and mental health workshops. We wrap this around with our social inclusion groups, running activities such as baby song time, yoga and mindfulness, art and craft and community groups down at the park. Our dads branch offers peer support and socialisation for fathers and partners. It is a clear strategic goal for us to continue to build on expanding what we can offer for men and non-birthing partners. We operate out of our three parent wellbeing centres at Caboolture, Mount Gravatt and Geebung. These centres are not just home to our peer-led services but are also hubs to co-locate with other services. Integrated care is a utopian vision for us.

**Mrs Farmer:** To provide a quick overview, 2021 statistics showed that we delivered a total of 1,014 group sessions across the period from January to December, averaging facilitation for approximately 21 groups every week. We had 3,196 attendances by parents—averaging 67 parents attending our services each week. Of the services provided, 50 per cent were within our focused, targeted mental health category—that is, our Just Peachy Peer Support groups for mums, pregnant peaches and dad brain peer support for dads. Some 32 per cent were across our social inclusion activities, as Viv just mentioned—baby song, community park, mindfulness yoga. Some 18 per cent were across our parent education part of the business. That is mainly focusing on our internally developed Sunshine Parenting Program and Circle of Security parenting program which is facilitated by our registered Circle of Security educators.

With regard to referrals, we receive over 1,000 referrals a year. It equates to around 2,060 referrals a quarter. Some 53 per cent of the referrals we receive via our website are from health professionals directly and 47 per cent are self-referrals—people recognising that they are in need of individual support. Our largest referrer is the Royal Brisbane and Women's Hospital, closely followed by Metro North Hospital and Health Service and their perinatal wellbeing team and then the Logan Hospital. Other referrers include our esteemed colleagues at the Mater, GPs, child health, private practising psychologists, social workers, midwifery practices and smaller non-government organisations.

The Sunshine Parenting Program is our signature program at Peach Tree and began our journey. It is an early intervention program for mothers experiencing or at risk of experiencing mild postnatal depression or anxiety symptoms. It is a six-week program that was written by Viv and me. It is delivered by facilitators with their own lived experience of perinatal mental health challenges. We formed a robust 18-month evaluation, measuring impact and process outcomes around the Sunshine Parenting Program when it was first funded and those outcomes were incredibly positive. Impact outcomes for attending were that mothers showed clinically and statistically significant results across parental confidence, quality of life measures, anxiety, depression through the EPDS score and help seeking confidence. We do pre- and post-survey questioning with the mums who attended the program in that 18 months but also with a focus on our peer workforce as well—so what did they need during this time in order to effectively deliver the program in the context that it was needed.

All outcomes were very positive. We identified a lot of learnings. We were able to revise, change, implement, which is the beauty of what we do. We can learn and grow and change things on the fly. In the last six months of the evaluation we had implemented a lot of learnings and the outcomes were more positive still.

In terms of the peer-led facilitation aspect of the Sunshine Parenting Program, attending mothers mainly found their feelings of loneliness and isolation were made so much better through connection with other mothers. Their personal experiences of early parenthood were normalised and validated and they felt safe to share in a compassionate space with other people who understand and a facilitator who understands what they were going through.

We are four years in now and we have had over 500 mothers refer into our program. We provide an evidence base, highlighting the value of the perinatal mental health peer-led postnatal wellbeing interventions. We receive funding support from the Brisbane North and Brisbane South PHNs in order to deliver the Sunshine Parenting Program in Brisbane North, Moreton Bay and Brisbane South. The Sunshine Parenting Program is a strategic tool to prevent mild mental health presentations from escalating into psychological therapies and/or hospital services.

**Mrs Kissane:** Our achievements have not been without immense challenges but it has taken a decade of advocacy and credibility building to get us to the point where we feel we are just at the beginning of something that could bring about significant change and impact throughout the continuum of care of perinatal mental health needs. As Dr Elisabeth Hoehn from QCPIMH stated in her session on 11 February, perinatal and infant mental health has only been funded for approximately 10 years. A lot of progress has been made in that relatively short period, and I do want to acknowledge that.

Unfortunately, most of the broader mental health system is not designed to be family focused nor are staff members trained to understand the significant complexities of perinatal and infant mental health. This means we still do have parents, carers, infants, children and families who are not getting their mental health needs met and who end up in quite dire circumstances. If we are truly wanting to look at preventing mental illness and reducing complex trauma, we need to be looking long and hard at perinatal and infant mental health and making a significant investment to minimise childhood trauma, increase parenting supports and improve access to specialised perinatal and infant mental health care.

There are many areas in need along the perinatal and infant mental health continuum that are critical. The immediate opportunities where we see ourselves being able to continue to grow and make an impact on mental health outcomes for Queensland families are in the following areas: continuing to work with other services such as the Mater and Catherine's House about embedding appropriately trained and supported lived experience professionals including into multidisciplinary care teams in both clinical and community settings; continuing to build our villages of support and local communities with our parent wellbeing centres; and delivering whole-of-population parenting education and perinatal mental health literacy. We are happy to answer any questions you have regarding our work and the need we see in our community.

**Mrs McMAHON:** Thank you to everyone for the work you are doing in this space. Looking at the submissions I note the statistics that we see in the perinatal space that are of concern. I was reading about the one in three mothers who describe their birth experience as being traumatic. I am interested in what is being done or what programs are in place, particularly for those who come through NICUs and other neonatal special care nurseries. I note your comments about the issues that parents who go through the NICU process suffer when they do not get to develop that attachment. Are there any long-term programs for families as they graduate from there, considering the level of inherent trauma involved in that NICU process? Is there something that Peach Tree does or something within Queensland Health guidelines in terms of following up the mental health risk?

**Mr McGahan:** Our engagement with mums and families in NICU is predominantly around that acute episode of hospitalisation. Our mental health teams—our perinatal psychiatrist and psychology staff—work with families in NICU. The longer term journey for those families probably ends with us at the hospital door—

**Mrs McMAHON:** With discharge?

**Mr McGahan:**—with discharge. I suspect GPs pick up a lot of that work.

**Dr Henry:** At the parenting support centre in the Mater we are able to see those mums at least until six months postpartum. I think you bring up such a good point. Being separated from your baby is certainly its own trauma and often an unanticipated complication for these mothers who go into preterm labour or have some complications post birth. Our perinatal psychologists and social workers at the Mater work quite closely to see those families while they have babies in the NICU. Then we follow them for six months if they are referred. They are recommended to come to us and we can follow that and offer them psychological support. After that I think there is certainly a gap. I am not aware of any long-term support that these parents get. We certainly try to do a very early intervention to try to help minimise and certainly recognise if these mothers have developed anxiety or depression symptoms and manage that.

A recent study of mothers who have babies in the NICU showed that 40 per cent develop an anxiety disorder. That is bigger than the perinatal population. These are mothers who I think we need to highlight and we need to be very serious about getting intervention to them quite quickly.

**Mrs McMAHON:** Is there anything that Peach Tree offers specifically in that space for NICU graduates?

**Mrs Kissane:** There is nothing that we specifically offer. We do see those mothers and infants but generally not until after six months when they have exited the hospital system and they are feeling confident and healthy enough to re-engage with community and come back into the community. Again, there is nothing formalised that we would offer them.

**Mrs McMAHON:** In terms of the hospital facilities—and I know there are recommendations around the mother and baby care units around mental health issues. In terms of parents who might not even be local to the hospital, particularly when you are looking at a NICU when there are so few of them and depending on the level of high needs of the infant, is there that space within the hospital or the grounds for the mother or parents where possible to actually remain close by and to help develop that attachment for as long as that infant is in the NICU?

**Mr McGahan:** We have a range of patient accommodation spaces where families will stay close to NICU. We try to make that happen as much as possible, particularly for families from out of town. There is also an app now so the family can keep an eye on bub while bub is in NICU. It gives them that connection. That is really what we try to do at the Mater; we try to accommodate the families as much as possible.

**Mrs Kissane:** I think it would be really valuable to look at how within that hospital service we offer peer support onsite while they are still admitted.

**Dr Henry:** I think the NICU is a really good example of how we can upskill a workforce. If you think about how many people are involved in that baby's care, there are paediatric nurses, paediatricians, neonatologists and social workers. Not everybody in their training as it stands might be really skilled in perinatal mental health or look at how we recognise signs and where to refer to. Everyone in the maternity space needs to be upskilled in perinatal mental health, and certainly the Mater is looking at how we can provide education programs.

The other point you raise is that the NICU parents can be a really good support for each other. We have been thinking about how we can educate or even offer support within a group setting for the parents who are there together. It is a shared experience that is unique to those parents. We feel there is a lot that can be done in this space that currently is not being done, but it is always on our minds to look at how we can develop that.

**CHAIR:** I wonder whether it is almost a cultural thing too whereby the team is often quite focused on the physical health and so are the parents. Then when that period is over, they kind of say, 'All right, we've solved that problem. Let's move on,' and do not think about those other implications.

**Mr MOLHOEK:** Thanks for coming today. I should declare an interest. My two granddaughters were born at the Mater, so I do not know whether that presents a conflict for anyone. My son and daughter-in-law chose the Mater for their two baby girls. Could you explain the difference between a perinatal bed and a normal maternity bed? I understand the differences around the issues. In terms of actually providing more of those spaces, is it a more specialist room or is it equipped differently? It occurs to me that some of our newer hospitals like the Gold Coast University Hospital and the Sunshine Coast University Hospital have significant maternity departments with all private rooms and ensuites. Is it around the people and the equipment, or is it a physically different environment?

**Mr McGahan:** I think there are a few differences. The length of stay in a perinatal mental health bed is probably about three weeks across the country. The length of stay in a maternity bed is quite short. That is one of the differences. The workforce that would care for you in a perinatal mental health facility is very different. Rather than being looked after by midwives and obstetricians, you are being cared for by mental health professionals. The look and feel of a perinatal mental health bed will be different. It would be less clinical. It would be more home like.

The facility we are developing at Catherine's House is almost like a small suite. You have a baby cot area, mum's bed space and there is a little lounge room as well given that people will be staying for up to three weeks. The other point of difference is that we are trying to develop some of the accommodation so partners can room in because that will be particularly helpful for the family unit. In some of our rooms we have a separate day bed so Nan or an aunty or someone could stay as well. They are very different types of services. They are licensed differently with Queensland Health. Our mental health beds will be acute mental health beds. We do have to consider safety in the mental health facility as well. It is that balance of getting the look and feel to be homely but also making sure it is safe for the cohort we would be caring for.

**Mr MOLHOEK:** We have a special unit at Gold Coast University Hospital attached to the mental health unit. I think it is called the Lavender suite. Is that the same as what you are talking to in terms of these perinatal beds, or is that a whole other level?

**Mr McGahan:** No, it is the same type of service. They are the only four beds in Queensland.

**Mr MOLHOEK:** That is what you were referring to?

**Mr McGahan:** Yes. My colleague Dr Branjerdporn works at the Gold Coast as well. She can probably talk to that unit.

**Mr MOLHOEK:** I assumed you had a four-bed unit at the Mater.

**Mr McGahan:** No. These will be new beds in the whole bed stock of Queensland.

**Mr MOLHOEK:** In your submission you talk about the prevalence of perinatal mental health issues in Queensland. It says we have one of the highest rates of maternal postnatal depression in the country at 10 per cent. Could you reflect on why? Is it because we are a far more transient community; we have a lot of people from interstate who come and go? I call it loosely 'paradise syndrome' where people come looking for new opportunity and hope and they leave all the connections behind and then they realise they need them. I would be interested to know if you have done any research or have any information as to perhaps why it is more prevalent in Queensland.

**Mr McGahan:** I will ask Grace if she has any thoughts on that.

**Dr Branjerdporn:** Compared to Victoria, for example, they have 33 perinatal mother-baby beds. They have the Parent-Infant Research Institute and they have a strong perinatal mental health focus there whereas, as Mrs Kissane was saying, perinatal mental health has only relatively recently been funded—in the last 10 years. I think it is also about the focus. When we look at the other mother-baby beds in Australia, the representation of Aboriginal and Torres Strait Islander women is only about three per cent whereas at the Lavender Mother and Baby Unit at the Gold Coast it is about 12 to 15 per cent. Perhaps it could also be the geographical dispersion and the tyranny of distance with Queensland being quite large compared to, for example, Victoria or New South Wales. Because we are so spread out, perhaps that is another contributing factor.

**Mr O'ROURKE:** Thank you for your submissions and being available this afternoon. My question is to Peach Tree. Looking at your page online you have Peach Tree online, which has a number of events that happen each day. Is there something like that available in central and regional Queensland that you are aware of?

**Mrs Kissane:** No would be the quick answer. I think there is definitely a gap of availability of services for those living in rural, regional and remote areas. That has the added challenge of people seeking mental health support in small communities where everyone knows everyone. More specialised perinatal and infant mental health services probably need to be created and adapted to reach those isolated communities. We should be looking at services such as e-PIMH, which QCPIMH deliver, Gidget Foundation's Start Talking, telecounselling and perhaps considering investing in those.

Peach Tree is not currently contracted to deliver any services outside of the Brisbane Metro area. In saying that, COVID did make us pivot and deliver our services online. We have continued to deliver about 30 per cent of our services online. We would certainly have the ability to do some more work within the regional and rural remote space if we had the resources to do so.

**Mr O'ROURKE:** I am not aware of any sort of prenatal services out there. I have spoken to different people involved with the Mater, women's health and things like that, but there does not seem to be any peer-led support. Thank you for your response.

**Dr ROWAN:** Thank you to both organisations for your submissions. I certainly believe you made a great case for strengthening a statewide perinatal framework around infrastructure and services in Queensland, particularly the disparity in Queensland that Greg referred to. I think it was one perinatal bed to every 15,000 births here and in Victoria it is one to 2,300 births. I think that articulates the disparity that exists. I wanted to ask about a specific element. There is a wealth of scientific and clinical evidence in relation to the neurobiological deficits and fetal harms associated with substance use and misuse during pregnancy, whether it is alcohol, tobacco, marijuana or other illicit substances. There is no safe level of alcohol consumption in pregnancy. I wanted to ask about FASD specifically—fetal alcohol spectrum disorders—using that as a broad term encompassing all of the disabilities caused by prenatal exposure to alcohol.

As part of reading these submissions and reading a bit more about perinatal mental health, the Queensland Child and Youth Clinical Network has indicated that somewhere between three to 10 children are born with FASD each day in Queensland. As part of the implementation of a further enhanced perinatal mental health strategy in Queensland, what further can be done to address that as a specific component of reducing substance use in pregnancy and the risks and harms to unborn children and obviously the risks of their being born with those conditions and then the further risks of them having mental health conditions and everything that flows on from that down the track?

**Mr McGahan:** We screen much better for mental health concerns than we do for drug and alcohol across all of our maternity programs. Sometimes people are more able to talk about a mental health concern than a drug and alcohol concern because of worries around child safety and a whole lot of other things as well. As we develop statewide programs and models of care, you have to think about drugs and alcohol and mental health as similar sides to the same coin. You need mental health professionals in that drug and alcohol space and vice versa. In our Catherine's House model we certainly are expecting to see mothers coming in with coexisting drug and alcohol problems. We will not be a specialist drug and alcohol withdrawal service, but we certainly will be able to care for the people who have that coexisting problem as well.

**Dr Henry:** I agree with you. I think it is a real gap. Coming through public maternity services, the screening is quite good. The Mater has a Champ model where midwives follow women who have substance disorders through their pregnancies. We have extended that recently. They get care for six months post birth—it used to be six weeks—in recognition that that is a real time for relapse. I think pregnancy is sometimes a good motivator for women to abstain. With the challenges that come postpartum, it is a real area of vulnerability. We are screening well through the public system when women are pregnant and trying to identify. I think postnatally it is really not happening very well because I suppose after that they are back to their own GP or their services and it is easy for women to slip through the cracks. We want to target women even preconception. It is part of a big public health piece. I refer to some of the recent ads outlining that no alcohol is recommended. You are right. We are clearly missing something given that the numbers of children affected and that we are seeing through the NICU service are still high.

**Ms KING:** Thank you all very much for being here. In particular, I want to acknowledge Peach Tree and the services you provide in my community through your Caboolture clinic. My question goes to antenatal mental health and particularly anxiety and depression, but I know that there is a fuller spectrum of mental health concerns that people can experience during pregnancy. My own experience was that that was difficult to access services for. What is there in terms of connected care for women through the antenatal and into the postnatal period? I recognise that perinatal encompasses both, and yet so often it seems to be the case that what may have been an antenatally occurring mental health issue does not get picked up until the postnatal period.

**Dr Henry:** That is absolutely correct. Screening has become much better in the last few years. The COPE guideline came out in 2017. It is a national guideline that recommended screening twice in pregnancy; so as soon as practical—so in the first trimester—and then again at around 28 weeks. This happens well, particularly in the public system. I think it is happening better through GPs. There is lots of education around the fact that we need to screen, but once we have screened the issue is around referral pathways. Even in the community with women who have the available resources to go to a private psychologist, the waiting times are significant. In fact, you are almost at the end of your pregnancy by the time you get seen. You make a good point. We know that 30 per cent of postnatal and perinatal issues have occurred in that period but have been either unrecognised or undertreated.

It is about educating people. GPs are probably seeing these patients more for primary care in their pregnancy as well as private obstetricians. Until the last few years, care has been siloed. It is like, ‘Oh, that is your mental health. Who looks after that?’ We are looking at being more collaborative in thinking that we all have a part to play in looking after our patients’ physical and mental wellbeing. One of the things we do with GPs who do share care with us at the Mater is we do education packages—a GP alignment program. We offer three. The third one has a big focus on perinatal mental health. That is about recognising that in pregnancy but not undertreating. There is still a lot of fear for the women and the health providers around using medication in pregnancy. We are really trying to overcome that because there is a real risk of not treating. We need to talk to mums about the risks and benefits of treating, but there is certainly a risk of not treating. We are seeing that in the postnatal period. It is about screening and helping health professionals manage those.

**Ms KING:** Does Peach Tree have anything to add?

**Mrs Farmer:** A large part of what we do is community awareness. Part of that is going into hospitals, talking to midwifery groups and health professionals and sharing a lived experience perspective, because often that is a lot more powerful than a clinical perspective of birth and parenting. We find that extremely beneficial. Peach Tree has an opportunity—and it is unique—to be able to sit beside all of these clinical services that do screen and assess during the antenatal, birthing and postnatal periods and complement that care. We can come in at any of those stages and are able to complement the care that the clinical physicians are already providing. We see that with our groups at the moment. A lot of mums just cannot get in to see clinical psychologists, psychiatrists and what have you. Peach Tree has become a bit of a holding space for a lot more complex needs than what we have traditionally seen. It is a big problem. I feel we can effectively work with the continuum of care model to help support in that space.

**Dr MacMAHON:** I have been lucky enough to have a look around Catherine’s House—it is still being constructed—and learn about the importance of those spaces where parents and their babies can be together. Can you talk about the costs associated with these recommended 40 beds and if you have any idea about where the best location would be for them?

**Mr McGahan:** We are going to deliver beds on the Mater campus, but the Mental Health, Alcohol and Other Drugs branch have been looking at beds across the state. They know there is a need for beds, particularly up in North Queensland and in the Brisbane North, North Lakes to Caboolture corridor as well. I am not sure that there is any planning further advanced than our program at the Mater at the moment. I do not believe there is any allocated funding for beds anywhere else at the moment.

**Dr MacMAHON:** Is there any research on the kind of experiences that mothers have during their pregnancy and whether programs like midwifery continuity of care have an impact on whether there are mental health impacts down the track?

**Dr Branjerdporn:** Absolutely. Models of care in midwifery play a big part. I was involved with the clinical guidance note for screening of perinatal mental health illnesses during COVID. What we found with that is that continuity of care models, like you are saying—and they could differ based on the needs of the women, whether that be birthing in our community for an Indigenous mother, perhaps looking at the Champ model, looking for alcohol and other drugs, substance use or maybe gestational diabetes; so different perhaps physical health complications or maybe a midwifery navigator model looking at perhaps mothers with high-risk pregnancies—are important so that we can be detecting mental health difficulties. We can be looking at domestic and family violence, maybe uncovering difficulties with substance abuse, things like that, because we are building that rapport and relationship and they know the women best from prenatal to postnatal. They then can refer them and link them up with different services post maternity care.

**CHAIR:** Are you aware of jurisdictions that have invested more heavily in perinatal mental health? Has there been any longitudinal data gathered around impacts on the development of mental health?

**Dr Branjerdporn:** At the moment in King's College London in the UK, they are doing a big national study looking at the longer term outcomes. They are comparing against an intensive home visiting model as well as inpatient mother-baby beds. What they are finding at the moment is that, because of the high risk of the mothers requiring inpatient care, that type of service is helpful in terms of their child development. As you know, mothers may be at high risk of infanticide as well as thoughts of harm towards their baby or neglect. What they are finding is that inpatient care has its place in terms of being able to provide that wraparound support.

**CHAIR:** We have heard a lot about this concept of adverse childhood events. Is that something that in the Mater services you screen for and track when people come through?

**Mr McGahan:** We do comprehensive risk assessments on all of our patients seen by our mental health services. They look at everything from child protection issues to mental health concerns through to drug and alcohol. We do screen for that. We do have some particular antenatal clinics which are more for high-risk parents. Those issues are certainly discussed in those forums as well—in the planning of birth, in the thinking about the mental health response and in all the other health responses that are required.

**CHAIR:** If you are screening for those things, it then obviously changes your care and your practices?

**Mr McGahan:** Yes, it does. An example of that is the birthing hospital for the Metro South HHS mental health service. We will often have a complex care meeting before a planned birth with the mental health team and with the consumer and have a plan in place to be able to support that baby and mother once the birth has happened.

**CHAIR:** Would you be of the view that the tools for screening for adverse childhood events are relatively well developed and could perhaps be applied more broadly across state government services?

**Mr McGahan:** We can always improve the tools we have. Evaluating the tools that we use and doing a little bit more research around them is important. We have talked a lot about risk screening and trying to intervene early. I think there is that balance between risk screening and then having some capacity to respond. Getting that balance right is, I think, the trick.

**Dr Branjerdporn:** There is the antenatal risk questionnaire that was recommended by COPE. At the moment there is no Queensland statewide perinatal mental health guideline. That clinical guidance note I referred to is the closest thing at the moment. That one recommends the antenatal risk questionnaire that looks at childhood events as wells your relationship with your mother, your birth trauma and a range of different traumas.

**CHAIR:** Presumably when people have been through your service, whichever part, wherever they have come from, wherever they are going to, many of them will have ongoing issues around housing, employment, education for their kids—all those sorts of pressures that come onto families—do you think there is value in some sort of community-based, ongoing case management for people who have had interactions with your services?

**Mr McGahan:** Yes, I do. The people we are able to refer on are probably at the more acute area and get accepted by community mental health services or a specific program. I think there is a lack of services out there for people who are at risk or in the mild to moderate level. I also think that Health does not need to do everything in this area as well. I think the peer models and other NGOs play a significant role in supporting that group of the mild to moderate.

**CHAIR:** That is a good segue because I did want to ask Peach Tree a couple of questions before we finished up. I am pleased to hear about your programs aimed at fathers as well. I was a primary caregiver there for a couple of years and there really was nothing in the community. Apparently the traditional model of taking your kids to the pub is not very good; you can only pull it off so many times. You mentioned in your introduction that you have a lot of people that are at risk of developing mental health engaging with some of your more group based services. Do you have valuations or tracking around whether or not those programs are successful in preventing people from then moving on to develop mental health issues?

**Mrs Farmer:** With the evaluation around the SPP program, the pre-imposed surveys were implemented for that exact reason, to see whether the mother began her journey with the Sunshine Parenting Program and then where she left her journey. We use what we call a warm entry then into Peach Tree services. The Sunshine Parenting Program can be looked at either way: from a more intensive support focus and then into a more community connected environment, but also the other way where women might come into the Sunshine Parenting Program or another Peach Tree social inclusion activity and then realise, ‘Maybe I am experiencing a bit of this,’ so do the program and then start engaging with our more targeted mental health programs instead.

The evaluation was highly successful, as far as statistical and clinical improvements around depression and anxiety. The other thing we noted was that for the mothers and individual cases, scores may have been higher in the six-week period at the end. Potentially the qualitative feedback around that was it would have been way worse had they not been involved in the Sunshine Parenting Program at that time. All outcomes point to the value of the peer-led facilitation of such wellbeing programs, whether they are pregnancy, postnatal, early parenthood, and we have a lot of work going on always in trying to provide those sorts of supports for community.

**CHAIR:** That is interesting because I was about to ask about that. I was reading an article about a police force that could not get officers to involve themselves in anything to do with PTSD courses, but when they started running fitness programs and other sorts of programs, just by engaging, they had a high success rate of transitioning people across.

**Mrs Farmer:** It is a bit sneaky, but it does work. That is what we love about the model and the peer workforce that we utilise; it sits across all elements of that continuum of care so it can go in both directions, whether it be someone who has not yet realised that perhaps they are at risk or, for people who have been at very high risk, they can then reintegrate within the community with mothers who have also been there themselves.

**CHAIR:** I realise the peer workforce can be extremely diverse in terms of the contexts in which they work, but do you think we should be attempting to develop codes of practice and scopes of practice and training across the peer workforce?

**Mrs Farmer:** This was a big one.

**Mrs Kissane:** Yes, absolutely. Our primary function is in service delivery, but obviously a necessary part of that work has been our workforce development. We could not do this without developing our workforce. We have worked hard over the 10 years and learnt a lot, mostly through by making mistakes, but there is a minimum skill set that is needed for a perinatal mental health worker to be able to work safely and effectively in this space. We have taken our experience, what we know and have learnt, and we have mapped them against the core competencies of the Certificate IV in Mental Health Peer Work, as well as theTe Pou competencies from New Zealand, to come up with modules of training that we believe perinatal mental health peer workers should complete at a minimum to be able to do this work effectively. It is core principles of peer work—active listening, self care, peer ethics and that type of thing—as well as specialised perinatal mental health content, as well as completing really good training that also exist such as the ASIT, applied suicide intervention training, trauma informed care, and packaging all of that up together into a set of standards to which our workforce should be held accountable.

**CHAIR:** I think Winston Churchill once said that wisdom is learning from your mistakes and being excited about your next mistake—something along those lines. Do not worry about those mistakes. It obviously has been worthwhile.

There are no further questions from the committee at this time, so that will conclude the hearing for today. There have been no questions taken on notice.

On behalf of the committee, I want to thank both organisations for the fantastic work you do in the community. We know that the last couple of years have been particularly tough with COVID. The committee has very much taken a deep interest in issues around perinatal mental health, so your presentations and submissions have very much helped to inform our thinking. Thank you very much.

I would like to thank our secretariat staff for all your support over the last couple of days. I would like to thank Hansard for your good work. I better acknowledge Barry because he has been on the phone for the last eight hours, and our deputy chair who has been looking at himself in the TV. A transcript of today's briefing will be available on the committee's webpage in due course. I declare the hearing closed.

**The committee adjourned at 3.52 pm.**