MENTAL HEALTH SELECT COMMITTEE

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

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

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

TRANSCRIPT OF PROCEEDINGS

FRIDAY, 29 APRIL 2022

Brisbane

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The committee met at 8.30 am.

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

I would like to introduce the members of the committee. I am Joe Kelly, the member for Greenslopes and chair of the committee. With me are Mr Rob Molhoek, member for Southport and deputy chair; Ms Ali King, member for Pumicestone; Mrs Melissa McMahon, member for Macalister; Mr Barry O'Rourke, member for Rockhampton; Dr Christian Rowan, member for Moggill; Dr Amy MacMahon, member for South Brisbane; and Mr Lachlan Millar, member for Gregory, who is today substituting for Ms Amanda Camm, member for Whitsunday.

The purpose of today's proceedings is to assist the committee in its inquiry into the opportunities to improve mental health outcomes for Queenslanders. This is a proceeding of the parliament and is subject to the Legislative Assembly standing rules and orders. Only the 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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IWINSKA, Ms Emma, Chief Executive Officer, Women's Health & Equality Queensland

CHAIR: Before I welcome the first guest, I would like to note an interest: Women's Health and Equity Queensland is based in the electorate of Greenslopes. I met with them this week.

I now welcome Ms Emma Iwinska, who is the Chief Executive Officer of Women's Health and Equality Queensland. I invite you to make a brief opening statement and then we will go to the committee for questions.

Ms Iwinska: Thank you for the opportunity to come and speak to you today. Before I get started, I would also like to acknowledge the traditional custodians of the lands on which we meet today, the Turrbal and Jagera people, and pay respects to elders past, present and emerging right across this nation of nations. I would also like to acknowledge the important role that Aboriginal and Torres Strait Islander women play in maintaining the health and wellbeing of their communities. I recognise the significant impact of colonisation and racism in this country and the impact that has on the mental health and wellbeing of Aboriginal and Torres Strait Islander peoples.

I am here today to discuss gender as a social determinant of health and the impacts that has on mental health and wellbeing, and also strategies for increasing mental health equity for people in Queensland. I am from Women's Health & Equality Queensland. We are a not-for-profit organisation whose purpose is to advance the health and wellbeing of all women in Queensland. We have been supporting women right across this state for approximately 40 years. We currently have a women's centre in Stones Corner where a lot of the focus of our work is supporting women after experiences of gendered violence. We also spend a lot of time working with the systems that support women, so building the capacity and capability of other systems to be more person centred in the way they support women in our communities.

Gender inequity in Queensland is linked to domestic, family and sexual violence, unpaid caring work, higher hours of work with lower rates of pay, lower social status and limited access to reproductive rights for a lot of women in Queensland. There is also housing insecurity and financial insecurity. These all have high impacts for women. There is a clear link between these impacts and mental ill health for women and girls.

Queensland is geographically large. We are socially and culturally diverse. Not all women in Queensland are able to access appropriate mental health care. This leads to poorer outcomes and an increased burden on the health system. Australia has been falling on the global gender gap index. We are currently ranked 99 out of 156 countries in terms of women's health and survival rates. We are well below a lot of what would be considered Third World countries in that area.

We are putting forward four key recommendations for consideration by the committee. One is to include a focus on prevention and response to mental ill health among women and girls and a focus on promoting their mental wellbeing as a priority for the Queensland Women's Strategy. As part of the Queensland Women's Strategy we led a consultation around gaps for women's health in Queensland. Something that has come out of that with the Queensland Women's Strategy has been a commitment for Queensland to develop a women's health strategy, hopefully by the end of this year. We see mental health for women and girls as being a key part of that, and we need to make sure this includes a focus on life stages and the impact of life stages on women's health and wellbeing, particularly adolescence, the perinatal period and menopause, which have high rates of mental ill health for women and girls.

We recommend the re-funding of the statewide midwife check-in service which uses a trauma informed and continuity-of-care model to provide non-clinical midwifery support and counselling to women across the state. Women's Health & Equality Queensland was funded to provide this service up until 2020. With funding priorities moving between different departments at the time, that service was no longer funded by the Queensland government. We noticed peak impact with COVID. When COVID hit, we had an almost 50 per cent increase in service demand as hospitals ceased providing the same level of support around the perinatal period, we had hospitals no longer providing childbirth education classes in person, and women's antenatal appointments were being reduced. This was a really significant impact for pregnant women in the state. We noticed a huge rise in the need for this type of service during that period.

Midwife check-in has been running for a really long time in Queensland. It has well-established links to perinatal services attached to hospitals. We would often receive a lot of direct referrals from antenatal teams with women at high risk. We know that the perinatal period is really high risk for mental health, including anxiety, depression and postnatal depression, and also really high risk for domestic and family violence to occur during that time. Our service model uses a combination of both midwives and social workers/counsellors to provide continuity of care for women right through this period.

Our third recommendation is around building the capacity of health practitioners and health services to provide gender-responsive, trauma informed care to women and girls. In 2020 we undertook a survey of Queensland women. One of the biggest needs in the community was around mental health and having appropriate trauma informed responses. We know that women experience much higher rates of gendered violence and abuse in the community, and the impact of that on mental health is huge.

We know that the Victorian royal commission found the need for segregated mental health services, particularly around inpatient services, and that was one of their key recommendations. They have brought in a mandate moving forward that all of their high-needs wards are going to have mandated sex segregation, because we know that mental health inpatient facilities are certainly places where women sometimes experience sexual assault and sexual violence. For women who may have strong histories of trauma or abuse, the act of being restrained by potentially big men is highly traumatic for them, and that is something that came out of the Victorian royal commission. They are making a move to move away from restraints in all inpatient facilities for that reason, because it exacerbates essentially the impacts of mental health.

Our fourth recommendation is around addressing violence against women as one of the biggest health issues. We know that it is the biggest health issue for women aged 18 to 44 in our community, and it is one of the biggest contributors to mental ill health for women. That is the end of my opening statement. Are there any questions?

CHAIR: There certainly are. You mentioned that your hotline provided non-clinical advice to women. What does that constitute?

Ms Iwinska: It could be women calling up because they have a colicky baby, the baby is not sleeping, they are not coping with lack of sleep or the lack of social support. It is really about having the expertise of a midwife, which we found was really important.

A lot of women during that period might not be able to identify that they are suffering from mental ill health, so there may be a huge gap—potentially a year down the track—before they realise they had postnatal depression or they had really bad anxiety, but when they are in it they cannot necessarily identify it. We found that midwives were a really great access point for women during that perinatal period. We have women during pregnancy who might have really escalated anxiety, but for them it is manifesting as worry they will have a miscarriage—worry about all these other things. They are not sleeping. They are not identifying that they are having a mental health impact, so they reach out for the midwife support. We found that that was a really key access point.

There is still a lot of stigma around mental health. Not everyone necessarily wants to identify that they are suffering from a mental illness. We have found that some of these soft entry points are important. Our midwives have specialist training in trauma informed practice, in being able to identify violence in relationships and homes, and they look for red flags for women so that they are able to be that key support often for women through pregnancy and out the other side.

Because Queensland is so geographically large, a lot of women who need support may be three or four hours from a hospital, having their first baby in the middle of nowhere with nobody around to support them. Having the same person they can talk to every week, if they need, or every month or two weeks—it really would be driven by the woman's need and her risk factors as to how frequently we would engage—was really crucial. Particularly as a trauma informed practice, not having to retell your story and having someone who understands your journey was a really key part of the success of that initiative.

CHAIR: Can I ask about this practice you refer to as trauma informed care? In a practical sense, what does that mean? I am a nurse working in a rehabilitation ward. How does that change my practice?

Ms Iwinska: It is about being able to recognise all the impacts that someone may come into a space with. Mental health is one of the key areas where the impacts of trauma will play out in different ways. It may mean that someone does not want to be touched. It may mean that someone has what would be considered an abnormal reaction to something that someone else would find a normal occurrence. It is really about having heightened awareness about how the impacts of trauma manifest. There are a lot of strategies that can be put in place to navigate those.

Dr ROWAN: Thank you to Women's Health & Equality Queensland for the submission. I wanted to follow on from the member for Greenslopes around gender-responsive, trauma informed care. Throughout our hearings there have been a lot of discussions about potential for a whole-of-government trauma strategy, given that people suffer—and particularly women—from traumatic episodes and then access different services. Do you have any thoughts on how a whole-of-government trauma strategy might work in Queensland, particularly as it relates to women?

Ms Iwinska: In terms of a trauma strategy, I think it is really important that every single person who is working in the health system is trained in the model and it is used really successfully in a whole range of places. In terms of putting a gendered lens on that, if you think about social expectations, women often are not allowed to show anger, whereas if a man is having an episode, let's say, and he is really angry, that is considered to be normal behaviour for a man; for a woman that is considered to be escalated. In terms of health care, we still see different types of dispensing. If a woman presents with pain, she has high chances of being prescribed a sedative whereas if a man presents with pain, he will be given painkillers.

We have all these gender biases that are imbedded not only across society but also in health systems. Probably the most common one that people are aware of is around heart attacks and the way that women present with heart attacks. We know that women are dying because the health system is not built to recognise the way that women present with heart attacks: that tends to be vomiting, dizziness and they are often sent home. They do not tend to get the big, sharp pain, clutching the chest manifestation. There is a lot of evidence out there, too, that demonstrates the biases that exist in the health system towards the way men and women are treated. It is a big capacity-building piece and a big education and training piece to really look at how we create a health system that is responsive to women's needs because we are still a long way from that.

Dr ROWAN: Further to that around some of those biases, are there any access barriers for either alcohol and other drug services or mental health services, particularly for women, that your organisation has identified?

Ms Iwinska: There are aspects around child care if they have children and how that looks. If you need support, certainly inpatient care with children is not really an option. I think there are strong biases, again, around gender segregation. You really need to have gender segregated alcohol and drug facilities; it is really important. Again, it is around gender responsive. I think there is real opportunity to undertake co-design, and undertake co-design with different cohorts in terms of what a good alcohol and drug service looks like for a woman from this background, compared to someone with a disability. There is not only the gender but also a strong intersectional lens to look at how you create responsive health services.

CHAIR: Before I go to the next question, can I ask you to table the document that you have brought in today?

Ms Iwinska: Yes. I would like to table the document, please.

Mrs McMAHON: Thank you very much for coming in. Turning to the trauma informed care model, your submission specifically refers to cultural competency. I have been involved in transporting women up to ED following sexual assault and other violence related issues. Can you briefly step us through, from that first initial contact with Queensland Health at an ED following gender related violence, what that looks like in terms of that care, that focus and then after the contact as well? Obviously it is quite a traumatic experience the person has been through, but the hospital process is equally traumatic. What can Queensland Health or those staff be doing? What would facilities need to look like to minimise that impact at that first point?

Ms Iwinska: We know that with trauma informed practice it is around creating safe space. How do you build a safe space? It is about making sure that the person is leading the process. A lot of it is around asking them the questions. What do they feel comfortable with? What would they like? Who would they like to be with them? How would they like this process to happen? It is ensuring the person is the centre of the whole process.

I think probably the best way to approach it is to work with a lot of women who have gone through the process and actually get them to tell you what they would like. It is going to be different for different women. I think part of that is that is what makes good trauma informed practice—providing the opportunity for different people to have flexible approaches so that different people can talk to you about what works for them, because it will be different for different people.

There are certainly key things around not retelling your story over and over again and making the room as least clinical as you can, because nobody feels safe generally in a clinical room. There are a whole lot of those types of things that can be put in place. I think you should centre the person's needs and structure the process around them. Often clinical settings are set up for the hospital's process rather than the person's process. It is looking at how you can still meet the hospital's process while making the person the key expert in what should happen for them.

Mrs McMAHON: Does your organisation have a view on the one-stop shop model for domestic violence and sexual violence victims. That is, instead of going to EDs you have those facilities and all the services there.

Ms Iwinska: There would absolutely be advantages to doing it in that way. With our centre, we have brought in a GP and other people because we see advantage in creating one safe space that people can go to. I am not sure how you would roll it out across Queensland—the logistics of it.

Dr MacMAHON: Your recommendation 1 talks about prevention. Could you elaborate a little bit on that and how your service might fit into a prevention space?

Ms Iwinska: For women and girls we know there are huge issues related to body image. There are a lot of structural issues that feed into women's and girls' mental ill health—social media et cetera. I think there are opportunities to start working more closely in schools and really think about the ways in which, as a community, we can start reshaping the way we view women and girls in our society. There has been some great work done in other parts of the world looking at advertising—pulling advertising out in terms of body image and the way that women are objectified in many instances, in billboards, as you walk past. There are all these types of structural things that can be put in place to ensure young people have equal value, no matter what their gender or gender identity is.

There is a key piece around ensuring everyone is equally valued. We also know that if we can get into primary schools it makes a really huge difference. We know that by the time young girls are aged eight their self-confidence plummets. They still have not figured out exactly why that occurs, but they think it is something to do with messaging that society gives young people in that young boys are continually told they are strong and they can do anything—they are capable—whereas young girls by the age of eight seem to be getting a lot of different messaging happening.

They did some great research with teachers where they found that if a young girl gets a good mark she is considered to be having to work really hard, but if a young boy gets a good mark then it is considered that he is naturally talented. There are these biases that we are embedding across our communities, and we have a great opportunity to shift those biases which will in turn have flow-on effects in terms of mental health and wellbeing.

There is also a big piece around sexual violence for young people and the impact that has on both men and women. We know that young women are five times more likely to be victims of sexual assault while they are teenagers and it is young boys who are perpetrating the violence. There are impacts for both the perpetrators and the victims in that situation and mental health impacts there. There is a big piece on that.

Dr MacMAHON: What would be the cost for re-funding the statewide midwife check-in?

Ms Iwinska: Could I get back to you with that?

Dr MacMAHON: Sure.

Ms KING: Thank you for coming in, Emma, and for all of the work that you and your organisation do. I have some questions about the delivery of alcohol and drug services in gender segregated settings. You have clearly expressed the aspects of segregated settings in mental health treatment that make it best practice. Can you speak to us a little bit more about the delivery of AOD services in a segregated setting? Is it because there are different relationships with substances between men and women or does it come down to trauma, or is it a range of things?

Ms Iwinska: I think it is absolutely a range of things. There are different pressures. There are different relationships as to why people end up using substances. We know that generally there is a trauma response particularly for women around substance abuse, that that is their trauma response. We know that when there is domestic or family violence the likelihood of alcohol and drug use for the victim is through the roof. I think for someone who has been a victim of domestic, family or sexual violence for a long period of time, that is the reason for their alcohol and drug use. If they get put into potentially an alcohol and drug rehab centre and they are possibly being surrounded by a cohort of people who represent men who have perpetrated the violence, it is not really conducive to actually going through a healing journey.

Ms KING: In terms of residential alcohol and drug treatment, do we know whether it would be likely to be the case that a woman entering treatment would be in the minority in a gender sense in that setting?

Ms Iwinska: I do not know the statistics, sorry.

CHAIR: Can I ask a bit more about this segregation concept? I have limited experience in mental health, but when I did have a period of time there as a worker, wards were segregated at night, but I have to say that nothing much in that facility in those days was actually secure from anyone—except for the locked ward, which was a forensic ward. If we segregate people in terms of their sleeping arrangements, it would seem to me there is still a lot of movement during the non-sleeping periods of the day and a lot of potential for violence and abuse. Have there been attempts to deal with that aspect of the care in the Victorian models?

Ms Iwinska: I do not know. I cannot answer your question, sorry. I know that there certainly have been a lot of requests from the community to make sure the communal areas are segregated as well, but where they got to that with the recommendations I am not sure.

CHAIR: Would it be preferable to have individual rooms for people rather than shared sleeping arrangements if that was achievable?

Ms Iwinska: Absolutely.

CHAIR: I would like to thank you very much for coming in and presenting today. The submission you have tabled and the presentation have been extremely useful to the committee and will certainly inform our thinking as we move forward. Thank you very much for the work that you, your volunteers and your staff do. You took one question on notice. We need a response by 12 May.

Ms Iwinska: Thank you so much.

MILLER, Miss Dawn, Acting Director, Mental Health, Alcohol and Other Drugs Service, Torres and Cape Hospital and Health Service (via videoconference)

SCHEFE, Mr Samuel, Director, Mental Health, Alcohol and Other Drugs Service, Torres and Cape Hospital and Health Service (via videoconference)

CHAIR: Good morning to you both. I invite you to make a brief opening statement and then we will go to the committee for questions.

Mr Schefe: Thank you very much. I want to open this morning with an acknowledgement to the traditional owners and custodians of the land on which we all meet and pay our respects to elders past, present and emerging. I also make an acknowledgment of those with lived experience of (inaudible). The Torres and Cape Hospital and Health Service is the most northerly Queensland HHS. We cover 158,000 kilometres over 13 local government areas. We cover as far north as Saibai Island—a stone's throw from PNG—as far south-west as Kowanyama and then south-east across to just south of Cooktown, to the Laura-Lakeland catchment. We provide care to a resident population of just over 25,000 people, of which (inaudible) background. We have 31 primary healthcare centres and four hospital sites that we provide outreach and community services within.

Our Mental Health, Alcohol and Other Drugs Service provides multidisciplinary specialised mental health and alcohol and other drug services focusing on intake, assessment, consultation, liaison and case management. Our team consists of around 65 positions that are based across our five main hubs of Weipa, Cooktown, TI and Bamaga. Our Cooktown and Weipa service are the only sites where we have a dedicated alcohol and drug specialist service. The rest of our staff are mental health and alcohol and drug dual-diagnosis rural generalists trained positions. (Inaudible) coverage is provided by our partners at (inaudible) Queensland Hospital and Health Service, of which there are three consultant psychiatrists with registrar positions. They are within the Cairns pool and they provide travel and outreach to those services generally one week out of a month to various sites at the larger hubs and then one week out of a three-month period to the smaller spoke sites.

Adult and child and youth mental health services are provided across all of the locations, with operational management provided by the onsite team leaders in those larger hubs and the professional governance and the clinical governance by those (inaudible) psychiatrists in Cairns and also our childhood and youth professional league. All of our teams are supported and guided by our Aboriginal and Torres Strait Islander health workers within their local work units and also along with the Aboriginal and Torres Strait health workers and their local primary healthcare nursing staff within those remote sites. We have a (inaudible) wellbeing service based on Thursday Island that consists of allied health and outreach (inaudible) health workers. On Thursday Island we provide the culture, advice and counselling for the alcohol and other drugs services and for the intervention and prevention. It is the only site within the Torres and Cape Hospital and Health Service where we are providing those subacute services that the NGO historically provides—that is, step 1 in the stepped care model.

Our service delivery is Monday to Friday in Weipa and Thursday Island. In Cooktown we are currently running a seven-day-a-week service. That seven-day-a-week service provides virtual care or conferencing telehealth support to the rest of the HHS as well as to all of the 35 sites. Our Cape York communities of Aurukun, Kowanyama, Lockhart River, Pormpuraaw and Coen are provided a service on a FIFO basis. We have a team based out of Cairns that travel into those communities generally four days a week—either Monday to Thursday or Tuesday to Friday—and they spend their 40 hours a week generally in those communities. Whilst in Cairns they also provide follow-up to the consumers that may be in Cairns, whether it be an inpatient unit with step-up step-down facilities or they may be down in Cairns whilst they are following up someone in Cairns.

There are no designated mental health beds within our Torres and cape region, so within our four regional hospitals we often will provide admissions which are generally to prevent further admissions down to the Cairns Base Hospital, which is the acute and designated mental health facility for our area. Whilst our consumers are within those facilities, we have our community outreach mental health team out to provide inreach services, so it is the general hospital staff that will provide the day-to-day care. However, for the morning shift and afternoon shift we ensure there is one of our community mental health services that provides an inreach assessment and provides support to those consumers. We do not have any alcohol and other drug detox rehab or adolescent specialist beds in the region either and the step-up and step-down facilities are further south in Cairns.

Over the last three years, one-third of the referrals are coming from our GPs and from our emergency departments. That is our largest referrer. Some 55 per cent of the referrals are female, 45 per cent are male and over 65 per cent have (inaudible) background. Most significantly, we have seen an increase in the referrals of the 12- to 17-year-old age group. Consistently we are seeing around 1,200 referrals to the Torres and cape mental health service within a year and generally around 40 per cent of that convert into an open service episode. Of our locum service episodes for our consumers, around 40 per cent of those consumers remain open for over one year and then another 25 per cent of those open episodes are open for longer than 90 days up to three months.

Currently there are minimal alternatives within the Torres and cape for tertiary mental health care or even in the subacute area. (Inaudible) for those places to be able to go to in our catchments through our hospitals and to be reviewed by our GP services, our hospital staff and then our mental health team, they come in on referral from the hospital staff at the primary healthcare centres. After-hours the acute mental health service is provided via videoconference from the Cairns acute care team. Cooktown is currently the only site that offers a seven-day-a-week service, so from eight till five o'clock on weekends it will be our Cooktown service that would provide that specialist mental health via videoconference and support to those other hub sites. Outside of those hours it goes down to Cairns and Hinterland.

Suicide prevention remains a key priority not only for Queensland but also for us. The PHN is taking the lead in this space, but at Torres and cape we are working quite closely with them on a multiagency response to suicide prevention by assisting with the Torres and cape community suicide action plan. At present there are no alternatives available to consumers who experience a suicidal crisis, with many seen by local facilities for support. There just is not the capacity in the non-government sector. With 35 remote facilities, even if the non-government sectors are funded they have issues with their workforce and capacity infrastructure to be able to get (inaudible).

At present we are exploring opportunities with the primary health network and the mental health brands to implement the wave back system, so a non-critical after-care service that provides support to consumers for up to three months post suicide attempt or suicidal crisis. We continue to work with the primary health network to strengthen our NGO capacity with support in commissioning those services within our catchment. We have an excellent relationship with our RFDS partners and we continue to try to work with Apunipima to try and improve their capacity within the space after they took over the wellbeing centres from the RFDS some years ago now.

As I mentioned, the psychiatry service is owned and governed by Cairns and Hinterland. At times not having the ownership over those consultants can be challenging. There are workforce issues with our medical workforce across the board. We are currently in the process of trialling a rural generalist model with our GPs on the local sites that are available to look holistically at the consumer to provide not just the mental health care but also the chronic disease and general primary care. That is something that Torres and cape would be really keen to be able to look at and somehow at the rural and remote sites have ownership over the funding and the FTE related to our medical psychiatry support and GPs with advanced skills in mental health so we have ownership over the potential for changing models and, should there be shortages at any points in time, we have the ability to be agile and adapt to that service model.

Looking at alternative (inaudible), we are currently trialling a GP with advanced skills in Cooktown. That is turning out to be pretty positive. The position is held by a GP who lives and works in the community currently. They are able to provide that holistic care. The governance still comes from the consultant psychiatrist that we currently partner with in Cairns but they are in the community, so we are not reliant on psychiatrists travelling in and out to those models. We know within our sites that it is so important to be able to build rapport and for the community to trust, and to have that type of support on site has been invaluable.

In terms of our workforce challenges, there has been a little investment within staff in the remote workforce over the past few years. We continue to experience challenges in recruitment and retention and we are competing with the other larger HHSs with regard to pool staff. Not only are we competing for the same pool; we actually have a reduced pool. For people to come rural and remote, there is a reduced population of staff members with the skill sets, of families and their personal circumstances to allow them to come out rural and remote. We are running at about a 7½ per cent vacancy rate—that is consistent over the last five years—with limited availability to access the specialised professional development for our staff. The team generally have to head down to Cairns, Brisbane and further abroad to have that type of training.

We are able to attract some nurses with some incentives with Remote Area Nursing Incentive Packages and some housing sites, but the other multidisciplinary team—allied health, health workers et cetera—do not have the same support. That is identified in the industrial awards. In terms of our health worker recruitment, that is again challenging the pathways for our Aboriginal and Torres Strait Islander mental health workers. That is something that we are really keen to make more robust so we have the appropriate skill sets for the staff. There are always challenges when we have small and remote communities in that there is a small pool of people who are able to step into those roles, so I think we need to have some alternative models to be able to provide that cultural support and that cultural brokerage in our sites there. Given our low critical mass with staff, that makes it difficult to support and develop a sustained pipeline of a mentoring program for graduates and training. However, we try our best, and certainly what we are seeing in our child and youth space is that we are getting some new graduates. They seem to be the pathway of staff coming on through into our workforce and we are making sure that we have a pretty clear mentoring model with them via videoconference, but ideally we would love that to be face to face or in person.

There are some other impacts that also hit our service working in the Torres and cape. We are heavily impacted by factors out of our control such as the weather. If the information technology goes down if we get a cyclone, the comms go down out in these remote sites. That creates barriers to be able to access the clinical information that we have and flights for our FIFO model for the psychiatrist travelling. If the airports are shut, the team are not able to get up there. We provide a backup in virtual care and videoconferencing support in the event of the aeroplanes, but, again, that is only reliant on the infrastructure. If the weather is that poor and the comms go down, the primary healthcare centre staff and the nursing staff at these remote sites are running solo at that point in time.

We are really reliant on our remote primary healthcare staff, and I think it is really important that when we are looking at our mental health workforce issues in these remote sites we also need to take into consideration workforce upskilling support for our primary healthcare centre nurses and our remote nurses, remote allied health, the health working workforce and the GP workforce that is out there.

We also have infrastructure issues out there, and that is part of the workforce issues in these remote sites. There just is not housing out there to be able to house staff. There is not enough housing out there for the local community as such and the socio-economic issues are generally what is causing these communities to be largely at risk, and that is even before adding the complexities of mental illness. I want to close by acknowledging the work that our mental health and our Torres and cape primary healthcare team does in providing a top mental health and alcohol and other drugs service to these communities in the Torres and cape region.

CHAIR: I acknowledge that you do not have specified beds, but when you do get an inpatient admission, is there an average length of stay, and do you have the staffing capacity to actually manage someone with a mental health issue who requires hospitalisation?

Mr Schefe: It depends on the location area as to where we are at. Within the larger hub sites—Weipa, TI, Bamaga and Cooktown—where we have hospital facilities, the nursing staff operate 24/7. They rotate through. We do have capacity in those sites to be able to provide the initial assessment and the initial support whilst we wait for the aeromedical retrieval. On average for the last three years, there have been approximately 20 retrievals or community members who have required inpatient care from the Torres and cape region. In those sites, yes, we do have capacity. On average the RFDS are generally getting consumers out within 24 hours of that referral. We only have two planes within this northern region, so if there is a cardiac arrest or a triage higher emergency, Retrieval Services Queensland may triage them higher and they will go and do that retrieval prior to coming to get the mental health retrieval.

In our remote primary healthcare sites in Cape York—for example, in Aurukun or Kowanyama—we run an eight o'clock to five o'clock service. When the patients or consumers come in and require retrieval, those nursing staff end up staying there onsite. Often there are only two or three nurses within those sites, so they are providing that care. If our mental health staff happen to also be in community at the time of those retrievals, they will generally also provide that level of support. However, that is an ongoing capacity issue. They normally are prioritised in the primary healthcare centres higher than what they would be in the hospital. Again, it is around the same time frames—within that first 24 hours. The gap that we do have, though, is that the RFDS—sorry, not the RFDS; it is Retrieval Services Queensland—will not come and do the retrievals for mental health consumers generally at night. If a consumer presents after five o'clock, they will generally be sitting in our primary healthcare centres or our hospitals until the following morning.

CHAIR: Just to be clear, for my understanding, if a patient is admitted to hospital requiring mental health care or psychiatric care, effectively they are there until you can get them to Cairns. That is what I am understanding.

Mr Schefe: Correct.

CHAIR: So would there be benefits of onsite, in situ, dedicated mental health beds or dedicated alcohol and other drug services?

Mr Schefe: The difficulty with our catchment is going to be the workforce. We have difficulty even providing our workforce currently. In most of the larger inpatient facilities, their workforce are not mental health nurses; they might be registered nurses working in mental health inpatient units. Even in the metro areas they are struggling to fill those positions. I genuinely believe that the service our consumers are getting is that they are treated with respect, and their treatment is commenced to at least make sure they are treated with dignity prior to the retrievals. We have 35 facilities, so it is really difficult to say where they would go. They are spread so far apart from one another, so it would be really difficult to have any one site that has that.

I think our larger facilities need capacity to have an appropriate mental health space—that is, a low-stimulus environment where consumers are able to be managed and where care can be provided whilst awaiting the aeromedical retrieval. In our primary healthcare centre space, they are generally sitting in an emergency treatment bay. In the larger hospitals they will generally be moved out of the emergency rooms into an inpatient room, which is more appropriate, but in those remote sites we do need to make sure there are rooms that are more appropriate for their care.

Dr ROWAN: Do you have any specific advice as to what can be done to further increase rural generalists with advanced specialised training in mental health and/or addiction medicine? I am also interested in nurse practitioners within those two clinical disciplines to support on-the-ground capability and then work in with those outreach services being provided from Cairns with respect to consultant psychiatrists and other mental health support.

Mr Schefe: Townsville already has a fantastic model set up for training of the GPs with advanced skills in that rural generalist in the medical capacity. It is around providing more access—whether it be scholarships or just support for the staff who have an interest in professional development and training to progress. There need to be some incentives for people to come out rural and remote and do that type of work. They are on the right track already. The mental health branch is in partnership with Townsville in funding it and doing that work.

With regard to our nursing workforce and our allied health workforce, that is absolutely something that we need to continue to progress towards. It is around how we partner with the universities to ensure the training that is provided is actually developing the skills and how you then provide the support with regard to what you are learning at the universities and then applying it to practise within hospitals. We need to have that partnership model, being able to work together. What you learn in a textbook is not necessarily the same as what you see when you are out here on the ground.

Mr MOLHOEK: You are talking about the challenge of attracting people into a fairly remote part of Queensland, and that is a common issue across many other areas of the state. What attracted you to the area? Why are you there? What do you see is the future for you in that setting?

Mr Schefe: I have been here now for 12 years. I was working with Cairns and Hinterland and I was working in the forensic mental health services. While I was in that forensic role I provided outreach to the Torres Strait and Cape York. I was able to have a bit of an insight into what it was like to go out rural and remote so it was not quite so scary for me when I did go.

The other part that really attracted me to this type of work was the autonomy of the role. We had a psychiatrist at the time who ran a fantastic model. It was more a population health model. He helped to open my eyes to the rural and remote work. It is very different. You are working with a lot more autonomy. When working in the metro areas in a case management model, it is very medically directed and you are probably not operating to the top scope of your practice as a mental health nurse, psychologist or whatever the professional background is. When I came out rural and remote, I was able to see how the teams were operating out there. The psychiatrist and the medical team have to trust the nursing staff on the ground. They have to trust the psychologists, the allied health and the health worker team who are out there on the ground, because they are not the ones with the rapport and the relationship with the consumer as such. They might only see the consumer once every six months, whereas the case management team and the clinicians on the ground are seeing these consumers multiple times within a week so they build those relationships. You are really able to work at the very top of the scope of your practice. In my experience in workforce capacity, that is generally what most staff are wanting for satisfaction in their role—that is, to have the ability to work to the highest level of your scope of practice and to feel you are contributing to better outcomes for consumers.

Mr MOLHOEK: Are you originally from a rural area?

Mr Schefe: I grew up in Brisbane and moved to Cairns about 15 years ago. I have worked with Torres and Cape now for 12 years and I love it.

Mr MOLHOEK: Good on you.

CHAIR: Can I pick up on that scope of practice issue. You have obviously had some work experience in Cairns and I suspect elsewhere as well. Do you think there would be benefits across the board if we had nurses or other health professionals working to a much greater scope of practice?

Mr Schefe: Absolutely. I think you touched on nurse practitioners earlier and the ability for us to utilise the nurse practitioners as well in this space. From a funding standpoint, and we have done this in Torres and Cape, we were able to amend positions. We have clinical consultant roles that are generally, from a financial standpoint in the system, funded around the same amount as a nurse practitioner, although the nurse practitioner has an expanded scope. They are able to prescribe certain amounts of medications and they have a higher level of capacity, so we have been able to create some nurse practitioner roles from within our own service to build that capacity. I think that is the type of thing that we need to be able to look at. We need that pipeline. We need to be able to get graduates in. We need to be able to train them to be higher level clinicians, to work in to being a clinical nurse consultant where they are more specialist within an area and then work their way into being nurse practitioners.

It is the same in the allied health field. We need to be able to upskill the staff so they can come in and understand the case management model, but then we really want to be utilising our allied health staff to be operating with regard to what their professional background is—so using a psychologist to do psychotherapy as opposed to just case management. They are the types of things we need to be evolving towards.

Dr MacMAHON: We have heard from some other witnesses about some of the challenges associated with emergency department wait times. Could you comment on whether that is your experience as well and how the Torres and Cape HHS is responding to that with regard to mental health?

Mr Schefe: I think we are really fortunate in these rural and remote sites that we are not seeing (inaudible). I absolutely feel for the larger tertiary hospitals with what they are dealing with. It is a whole system change that they need. In the rural and remote sites, people are moved through the system very quickly. They are presenting to emergency departments or primary healthcare centres and they are being seen almost instantly.

Miss Miller (inaudible)

Mr Schefe: The staff who are doing the assessment are also the first responders, or they are the retrievalists. We do not have an ambulance service in a vast majority of our primary healthcare centres. It is our nursing staff who are doing that. It is really only Thursday Island, Weipa, Cooktown and Bamaga where there is an ambulance service. Again, in smaller communities there are really good relationships and they are getting through the EDs quickly.

Dr MacMAHON: Could you also comment on the support you are offering for young people and some of the issues young people in the area are facing?

Miss Miller: We have child and youth mental health clinicians in each of the sites. They are linking in with schools. We have an overarching Ed-LinQ (inaudible) is also building in relationships with the schools. They have the therapies so they are very therapy driven. As an example, one of them is now starting Drum Beats with schools and the NGO partners. I think teens probably have that model that the adult team would love—where they are getting down, doing that therapy and working with the family, the school and that whole extended network. They are getting a lot of (inaudible) seeing that rise in referrals from that school based age group (inaudible) to the fact that there is a bigger presence now. On the plus side, we are seeing a decrease in referrals with that age bracket so it is the preventive space that is working; it is that early intervention.

CHAIR: I would like to thank you for presenting today. We would like to thank all of your staff, who work in some of the most remote parts of Australia, for the work they have done, particularly over the last couple of years in dealing with COVID-19. The presentation you have done today will certainly help to inform our thinking as a committee going forward.

Mr Schefe: Thank you.

LO, Mr Adam, Board Member, Occupational Therapy Australia

CHAIR: Mr Lo, would you like to make a brief opening statement? Then we will go to the committee for questions.

Mr Lo: Good morning, Chair and committee members. Thank you for the opportunity for contributions today to improve mental health outcomes in Queensland. My name is Adam Lo. I am a mental health occupational therapist in Queensland and I am appearing on behalf of Occupational Therapy Australia in my capacity as a member of the board.

It is our members' collective view that the Queensland mental health system is approaching a crisis point if crucial actions are not taken now. Members are voicing that mental health services across the board are being pushed to the limit and public mental health services are increasingly needing to focus on the most acute, severe, complex and high needs cases whilst most non-government and private services are experiencing long waiting lists. The COVID-19 pandemic only added to the mental health burden of our population and the demand on the mental health workforce.

Urgent investment by the Queensland government in mental health services is vital. This includes increasing support and recognition of occupational therapists, the third largest allied health workforce in Australia, and our important role in mental health. Support for targeted workforce initiatives such as increasing entry-level positions for occupational therapists, minimum number of discipline-specific staff required to support students, early career professionals and those in rural and remote locations, as well as increased allied health educator and coordinator roles are some useful actions.

The mental health system in Queensland requires alignment and cohesion across government, non-government and private services and also across federal, state and local levels to ensure that a whole-of-government and whole-of-community approach to healthcare delivery can be secured. This includes working closely with the primary health networks. The equity and accessibility of mental health occupational therapists to Medicare and Veterans' Affairs funded mental health programs as providers must be improved. The National Disability Insurance Scheme also needs to be more accessible for people with psychosocial disability. This will no doubt reduce the burden on public mental health services and inpatient facilities. This remains a major issue according to the members.

In closing, mental health occupational therapists are an essential part of a holistic, recovery focused, multidisciplinary mental health service. The unique skill sets and expertise we bring to improving mental health outcomes for Queenslanders, whether it be to live independently, to engage in paid work or to participate meaningfully in the community, are not just good to have but are a must-have for a successful mental health system of the future for all Queenslanders across their life span. Thank you for the time and opportunity today.

CHAIR: Thank you, Mr Lo. In your submission I believe you talked about the need to have occupational therapists involved in every clinical setting within Queensland Health. You also suggested some sort of ratios, I believe.

Mr Lo: I think there are probably occupational therapists across most settings already, not necessarily in the numbers that might be required or that would be beneficial to the services. OTs do work in education and health services across the community—inpatient as well.

CHAIR: You heard the discussion around scope of practice with the last submitter, I believe.

Mr Lo: I heard some of it.

CHAIR: What would be your view in terms of occupational therapy? Are occupational therapists receiving the opportunity to work to full scope of practice in mental health settings?

Mr Lo: I think that is a really good question, because we as health professionals do need to work within our scope of practice. Mental health occupational therapists are often probably not as well known as other mental health clinicians such as psychologists or even mental health nurses. Most people think of OTs working in the physical setting so it is really important that we are able to get the message out to not only the public but also other health professionals and GPs.

I did a little bit of private practice in the past. I remember that a client wanted to see me for mental health services and the GP was actually questioning the client as to, 'Why are you seeing an OT for mental health?' It is about liaising with PHNs, working together and educating even other health professionals so that we can really work together as a total mental health service and not, I guess, forgetting the important role that mental health OTs play in mental health. It is not only restricted to Australia. I am aware that even in the US it is not as well known that occupational therapists work in mental health and historically have done so, from the beginning of the profession.

CHAIR: In terms of the clinical objectives of an OT in mental health settings, is it about helping people who have permanent and ongoing impacts from their mental illness to adjust to life or is there actually a therapeutic attempt to reverse or cure certain mental illnesses?

Mr Lo: That is a great question. In the undergraduate courses OTs do get trained in mental health as well as physiology and anatomy. We have that fundamental knowledge in mental health. Then when an OT works in mental health they learn on the job or they do further training and studies. A lot of the mental health OTs would be trained in a number of therapeutic approaches—CBT or other types of therapeutic approaches—with the lens of an OT coming from a holistic view of a person, from a recovery focus perspective, and also looking at what is meaningful for the person. Instead of just doing therapy, we want to make sure that what we are doing is meaningful and can be translated into their everyday life to promote their independence and to increase their functioning.

OTs are, I guess, to summarise it, all about increasing the functioning of the person so that they can live a purposeful life. Mental illness or physical illness may have reduced their capacity to function at work, at home or in the community. What we try to do through different therapeutic techniques or programs is increase that independence and functionality across what they find useful. If they want to go shopping or play sport, it is about promoting that independence to achieve what is meaningful for that individual. I guess that is a little bit different from our perspective, but we do a lot of similar stuff in terms of the therapeutic approaches as a group, and as part of a multidisciplinary team.

CHAIR: Other groups have suggested the offering of scholarships to help people who are trained in a general health profession specialise into mental health. We have seen that rolled out in Victoria in certain professions. Is that something that Occupational Therapy Australia thinks would help to increase the number of OTs in mental health in Queensland?

Mr Lo: That would definitely be helpful because that would encourage students to think about an avenue of opportunity of working in mental health as a choice. You will find that, when we have new graduate positions where they rotate around, that is always a popular one because they get to experience different areas of practice and then they can decide whether they want to work in mental health or in physical rehab. Having scholarships or other programs that support new graduates and early-career occupational therapists will really give them that incentive to look at a long-term career in mental health. We do need more mental health OTs.

CHAIR: Does Occupational Therapy Australia have any suggestions or views on how we might encourage more OTs to offer services in rural and remote settings?

Mr Lo: As an association we have tried to provide supervision for OTs who are working in rural and remote locations because often they might be the only OT within the team in those locations and they can be isolated professionally and socially. We do try to match OTs who might be able to supervise them. The difficulty at the moment is finding people, because everyone is so stretched in clinical practice. People are finding it more and more difficult to provide that extra support for other OTs. We still try to provide supervision, but all the extra stuff like signing up for more work supporting those who are in rural and remote areas—10 years ago we would make a callout and we might get a few people put their hand up but now it is getting more and more difficult because people are just so under the pump, particularly in the last couple of years with the pandemic as well. All health workers have been moved around to fill certain gaps of need right now and so it is a staffing issue as well.

Dr ROWAN: In relation to occupational therapists, given that Queensland is a very decentralised state, for those working in community and primary care, are there any comments that you would have in relation to mental health care plans and case conferencing and the Medicare Benefits Schedule—the processes around that, whether there are any reforms or considerations that Occupational Therapy Australia would recommend as to how those occupational therapists providing services in mental health or even alcohol and other drug services can be further engaged into those processes?

Mr Lo: I think it is helping OTs from the state government also supporting us in our cause to really voice out to the policymakers who design the Medicare rebates and funding structure for mental health. Historically for occupational therapists, together with social workers, for example, the rebates are lower comparatively to psychologists. In the public system we all get paid the same because it is recognised that we are a multidisciplinary team and we bring value to the table. That kind of does throw off some OTs in terms of them wanting to see that as a career and making a career in private practice. Some get around it because then they charge a gap. I have OT colleagues who work in the private sector together with psychologists, clinical psychs and other people, and the rebates for their clients will be lower but then some clients are actually happy to pay that higher gap just to see the OT. Different clients get different value from different clinicians. Some do prefer an OT who understands some of the physical needs as well, and I guess that comes down to also the burden on the clients themselves when they are choosing if they would like to work with or see an OT. They do have to pay that extra gap. There are some inconsistencies that we have been trying to champion. That includes the Veterans' Affairs funding model whereby mental health OTs who have a lot of expertise have actually moved out because they have not been able to receive the incentives they require to stay. Some do stay because they just want to support the veterans, but they are not getting the recognition they deserve.

Mr O'ROURKE: With regard to your recommendations, you talk about supply and streamlining the NDIS process to ensure that people with mental health issues are supported. Could you talk to that and what the barriers are?

Mr Lo: I think the provision of NDIS is wonderful and it is improving over the years in terms of how it has been able to meet the needs of clients. Historically over the years it was difficult for people with psychosocial difficulties—or more difficult comparatively to physical disability for example—to obtain packages. We want people with mental health to recover. We work under a recovery model of practice whereas NDIS funding is for people with permanent disability. That goes against the way we want to work for the client. That terminology and how they see it has improved. Comparatively, about 71 per cent of psychosocial packages are accepted as opposed to 85 per cent for physical. That is a gap. It is about people who are able to get support to write up those NDIS package applications. A lot of the time people with severe mental illness are least able to be resourceful enough to get the right people, to get the right support for themselves. Then usually it goes back down to the Public Service. We find that some OTs in some teams are spending a lot of time putting packages together for people who need it and that takes them away from being able to do their clinical, face-to-face work with clients.

Mr O'ROURKE: By addressing some of the NDIS shortfalls we could actually address some of that missing middle, I suppose—if there could be a little bit more flexibility in that space for occupational therapists to step in earlier.

Mr Lo: That is right.

Dr MacMAHON: I was hoping to talk a little bit about your recommendations around housing. I know that occupational therapists interface a lot with the NDIS and social housing. What recommendations would you make in that space?

Mr Lo: Once again it is providing, I would say, more scope or more support for OTs regardless of what service they are at—for it to be recognised that they might be spending a lot of their time doing that in terms of supporting all the environmental aspects that will contribute towards the mental wellbeing of a person. We are not just doing that therapeutic, face-to-face stuff; we are looking at their connection to community. Do they have adequate housing? Do they have access to utilities and services? With OTs being holistic in our approach, like you said, we often get involved in that aspect of care. It is about particularly services that employ OTs understanding that that is a big role that OTs do contribute towards so they are given the support and resources to do so. At the moment I guess a lot of members and OTs are just saying that they are overwhelmed because they are trying to do that as opposed to their core therapeutic support and things like that.

Dr MacMAHON: I note also that your recommendations talk about an investment in community services to address broader contributors to mental health. Have you had a chance to look at some of the recommendations from the Victorian royal commission and whether those would fit in with what you might envisage?

Mr Lo: There are a lot of good suggestions that came out of the Victorian papers. I think for us it is how we can tailor that to each of our local communities. That is why we need to work with local council and local communities across the board, because each community would have unique challenges and unique needs that one set formula is not going to help. It is about giving that voice to the community and listening to all the constituents, including the occupational therapists who work within the community.

Mrs McMAHON: I take you back to the questioning we had around the mental health specialty within OTs. I am familiar with OT practices within the NDIS. My son goes to an OT for behavioural and emotional regulation assistance. I was wondering if you could talk about what that additional training looks like. I know that we have spoken about the incentives that might be needed for an OT to then specialise in mental health. Who delivers that kind of training, how long is it, what does it involve and then what additional specialties outside of that behavioural and emotional regulation can that OT provide?

Mr Lo: That is a great question. OTs vary in their levels of training in mental health. If an OT decides to work in mental health you see a variety. Some go and do additional postgraduate training themselves. There are a lot of workshops and training. All mental health OTs are supervised—all mental health clinicians—in their progression of learning and also making sure there is clinical oversight of OTs working in mental health. Mental health OTs who decide to work in private do need endorsement from OT Australia. They do need to show that they have at least two years of working in a mental health setting and that they meet the criteria and ongoing training and supervision to be able to work in a private setting to provide mental health care. In the Public Service there is a lot of in-house training and support. OT Australia provides mental health workshops and training, together with other types of training, because OT is a very diverse profession.

Mrs McMAHON: If we look at the recommendation that we have more OTs working in the mental health space within Queensland Health as part of a multidisciplinary team in acute settings, and even in community settings, what sort of endorsement or level of accreditation should we be looking at to be able to say, 'This OT has the specialisation to be able to work specifically in the mental health field.' There is a big difference between going on to postgraduate study in a field and doing workshops. There is a big variety in between. We were looking at multidisciplinary teams with psychologists, exercise physiologists and dieticians and everything yesterday. What level should we be looking at for the OT in that team?

Mr Lo: That is what we have been investigating as OT Australia: looking at whether we can provide some sort of oversight of OT training and capability as a mental health OT. We have looked at capability frameworks and a number of other things. At the moment there is what we called a white paper initially but now we are calling it Thinking Ahead, a project that is investigating the state of mental health OTs in Australia and how we are able to portray that—like what you are saying. Results are pending. We know that in recent years they have developed a credentialed mental health nurse process. That is a model that we have been looking at as potentially something we can do for OTs in the future. It is about OTs getting the recognition they deserve for those who have the experience and the skill sets.

Mrs McMAHON: Absolutely, and then consistency across the state, across the whole of Queensland Health, becomes important. That is something that your organisation would be happy to work with Queensland Health on, to set the guidelines?

Mr Lo: Yes, definitely.

Ms KING: I wanted to ask you to address us a little on the issue of OTs providing supervision for trainee and graduate OTs. You have described a scenario where the clinical workload is such that people do not have the capacity to provide supervision in the way that they once would have done. I recognise that as a profession, for any professional person, it is a deeply embedded part of being a professional that you want to foster future generations of practitioners in whatever your discipline may be. I wonder if, in the context of declining rebates and increasing costs, providing more financial support for that supervision factor may be of assistance in that space.

Mr Lo: That is definitely a great initiative because a lot of that is ad hoc and OTs volunteering to support those who are isolated in rural and remote communities or OTs who want some extra mentorship in certain areas of practice, like in mental health and some parts of mental health services. I think if people are struggling to do their core work and then if they have other roles as well it is really hard to have that initial volunteering role. If there is an incentive it may drive some people or maybe they can go part-time in some other work and then provide that support for those who need it as well.

Ms KING: I do acknowledge that what you are describing is clearly not that people are unwilling to provide that supervision on a pro bono basis; it is about the challenges of trying to meet workload. As you say, perhaps being able to do reduced hours might be of assistance.

Mr Lo: Yes, that is great.

Dr ROWAN: Has Occupational Therapy Australia had any feedback via its members in relation to COVID specifically and just any trends they are seeing?

Mr Lo: That is a great question. From what we have seen of feedback from our members, there is definitely an increase in mental health needs, particularly in youth. There could be a lot of factors, as with any mental health issues—isolated, not going to school for a number of periods and just the stresses that their parents or families are taking on as well that is coming through. It is not restricted to youth, but there is an overall increase. From personal experience with our team, our child and youth mental health team that I work with, we are getting a lot of need, people through the doors, increasing a lot particularly in the last couple of years. We cannot prove that without doing any proper research, but from experience it does seem like COVID-19 has increased the burden of mental illness in our communities and that flows on to a burden on the services as well.

Dr ROWAN: Are there any specific trends in those demographics, whether it is mood disorders, anxiety disorders, eating disorders or specific family issues, that are being picked up? Is there anything anecdotally or formally that Occupational Therapy Australia could provide?

Mr Lo: I can get back to you on that one because we have members who are doing studies in these areas and who are probably collectively able to provide feedback. If that is something that would be of interest, we can coordinate and mobilise all of our members to provide their views on what is going on at the moment.

Dr ROWAN: If you could take that on notice, that would be very helpful.

CHAIR: At that point we might bring it to a close. Thank you very much to OT Australia for taking the time to present here today. It is a very important part of the mental health workforce. We will incorporate your thoughts and views into our report and recommendations going forward. You have taken a question on notice. We would like a response to that back by close of business on 12 May.

COULSON BARR, Dr Lynne, Health Ombudsman, Office of the Health Ombudsman

GROGAN, Ms Karen, Director, Triage and Assessment, Assessment and Resolution, Office of the Health Ombudsman

CHAIR: I now welcome representatives from the Office of the Health Ombudsman. Can I ask you to make a brief opening statement? Then we will go to the committee for questions.

Dr Coulson Barr: Good morning and thank you for the opportunity to speak to the committee. I would like to start by acknowledging the traditional owners of the lands where we meet today, the Turrbal and the Jagera people, and pay my respects to all elders past, present and emerging. I would also like to acknowledge people with lived experience of mental health challenges, their families and advocates and particularly those who have brought their concerns and experiences with mental health services to the attention of our office, the Office of the Health Ombudsman, known as the OHO.

We know that people can experience a range of barriers and challenges in making a mental health complaint, particularly when the complaint is about a distressing and adverse experience. That is a common issue across jurisdictions across Australia and overseas. It is a known issue that our office is committed to addressing and ensuring that our processes are truly accessible, supportive and responsive. You no doubt know from my background as a former mental health complaints commissioner in Victoria that it is a key issue of priority focus for my role in terms of stepping into this work.

The OHO deals with complaints about health services and health service practitioners, and that includes mental health services in both the public system and private facilities and practitioners, so it is a broad scope. We have a really unique window into people's experience in the mental health system, and that is where complaints are so vital. They do give us that vital window into how people are experiencing the system and what is working and what is not. We know from the challenges that people bringing concerns to our attention and to services' attention that it is really incumbent on us to use that information to analyse what it tells us about the pressure points in the system and look at how we use that information to drive service and system improvements.

We know that commonly when people make a complaint they are making a complaint about their individual experience, but it is really common for people to raise an issue because they do not want the same experience to happen to someone else. That is why one of our priority commitments is to look at how we can better utilise our data and share it with others, to look at what are the key insights particularly about quality and safety issues that we can be identifying and using in a timely manner. I have commenced discussions with Queensland Health and the Chief Psychiatrist about how we can really join up the picture that we are seeing in the mental health system.

I also want to note that complaints really have a key safeguarding role in terms of people's rights, and that is a key issue for mental health consumers because of the interface of potential breaches of their rights and the way in which an assessment of complaints can identify those key issues. However, we also know that when there is an unresolved complaint or an unresolved issue that can have a deep impact on someone's recovery journey, but also it can lead to them disengaging from services. There is a lot at stake when we are dealing with mental health complaints.

One of the messages we are wanting to promote with services is not to see that complaints are on the side—they are a form and a process—but that they are integral to people's treatment and care, because if there are unresolved issues, particularly an adverse event, that really needs to be addressed.

The types of issues we have identified and complaints made to OHO really mirror many of the themes that you have no doubt heard throughout your inquiry process and they also mirror the other mental health inquiries of the Productivity Commission and Victoria's royal commission. We have outlined the range of issues in our submission. We can talk more about those details later. Some of the key concerns, not surprisingly, are about access to mental health services in crisis in a timely manner and service availability in general, but particularly for rural and remote areas, and one of the themes we have identified is also for young people and children, particularly specialised services. There are a range of issues around discharge arrangements and transition and coordination care that you have no doubt heard throughout your inquiry and particularly around that meaningful engagement with families and around risk assessments and the most appropriate response to risks that are identified by families about their loved ones.

A broader issue, one that we have a key insight to, is concerns around personal and sexual safety within mental health facilities and in people's experiences in accessing mental health through emergency departments. We have a particular window. We are more likely to see those pressure points of the system. We see, unfortunately, the use of restraint enforced by security guards in a situation of crisis in a busy emergency department, but we also have received some really disturbing complaints around incidence of sexual assault in mental health inpatient units. That is not a unique issue for Queensland—it is a known issue and a risk throughout Australia and overseas—but there is a range of strategies that can be undertaken to address that particular issue. I have commenced discussions with the Chief Psychiatrist and others about how we can have a targeted approach on that particular area of risk.

In closing, I would just like to reiterate the importance of an accessible and effective complaints and regulatory system for achieving improved mental health outcomes and service delivery. We are really committed to building on the strengths of OHO's model because it has a key strength—it was one of my attractions of stepping into this role: the strength of having a single point of entry for health service complaints. We cannot underestimate the importance of that. There is also the capability of making verbal complaints and making that an accessible process. That could be a huge barrier if people feel they can only make a complaint in writing.

There are a range of strengths of our current model and our close collaborative work with Ahpra that we can build on, and we are really committed to working more closely with a range of stakeholders in the mental health system in terms of how we can share our insights. Thank you.

CHAIR: Would you have any indication of the percentage of complaints that you receive relating to mental health services?

Dr Coulson Barr: It is an area that we have identified that we need to get better data on, the way our data collection system does not easily identify complaints made by mental health consumers, because we can receive complaints around a whole range of types of health services and practitioners. To address that, and through discussions with Queensland Health, we are building what is called a data warehouse so that we can extract all the data from the back end of our case management system and do more granular analysis of who is making the complaints, where they are from and what is the nature of issues. We are going to be working on that over the coming months. It is something that we cannot easily extract from our current system. We can probably give some indicative figures, but I would not be able to give you a reliable figure at this stage. It was the key issue that I identified in stepping into this role and one of my first tasks was actually writing this submission, so it has formed part of my priority focus of how we can actually identify and share more meaningful data about what we are seeing.

CHAIR: Does the OHO involve people with lived experience in the design of the services and the way you manage complaints from mental health consumers particularly?

Dr Coulson Barr: It is something that I do not believe we have done in a targeted way to date, but it is certainly an area of focus in terms of stepping into this role. I have had beginning discussions with the Queensland Health consumers, and I will be talking to the peak mental health consumer body as well. We do look at lived experience as part of our recruitment experience, but I would like to defer to Karen if there are some examples that we could give there.

Ms Grogan: We are, of course, very keen to hear from people who are making complaints who have lived experience and, in a very consultative way, seek their views about how we can support them through the complaints management process, specifically how we manage the complaint that is going to address their needs: the way that they need to be communicated with, the forms of communication and the timeliness of the communication. That is very much part of our process.

In September of last year we initiated a new model, a complaints navigator model, to support people who are bringing very serious and complex complaints to us. They are typically complaints where people have been sexually assaulted or involved in a boundary violation with a practitioner, and this model supports people end to end through the complaints management process. One of the liabilities we face is that if people become overwhelmed and they disengage in the complaints management process, that can in some instances draw the complaint to a close. That would impede the Health Ombudsman's ability to protect the health and safety of the public. This has been a really important initiative for us to support people through this process end to end, so through the various processes right to the end where a matter might be being prosecuted at QCAT.

CHAIR: The OHO accepts anonymous complaints. How do you protect the practitioners from vexatious complaints? How is it possible to ensure natural justice for a practitioner if people are able to make anonymous complaints?

Dr Coulson Barr: The first response would be that we have to have a very clear and rigorous process in terms of how we assess complaints and in testing the evidence that we are being presented with and the motivations for making a complaint. We are obliged to conduct our processes with the light of procedural fairness, so it is about putting the information to the practitioner in a fulsome way and giving them the opportunity to respond. The capacity to make an anonymous complaint is also a key safeguard for a range of reasons. Some people can be reluctant to make a complaint, so we need to have those protections for complaints to make sure that we are receiving those critical safety and quality issues being brought to our attention. I will defer to Karen, if she wants to add to some of our specific processes.

Ms Grogan: Yes, thank you. As Dr Coulson Barr has pointed out, it is an important process. It is provided for in the legislation that any person can make a complaint and they do not need to identify themselves in that process. Clearly we apply a very strict lens over a complaint where there might be an index of suspicion around the veracity of it or if it might be of a vexatious nature. The legislation gives us a mechanism to withhold notice from the practitioner about the complaint while we make initial inquiries on that matter, and if the complaint is found to be vexatious or significantly lacking in substance we have the option to take no further action on that matter and the practitioner will not be made aware of it. The legislation provides for no notice being provided to them so that they are not aware of that if that is deemed to be appropriate in the circumstances.

CHAIR: Would someone making a very similar complaint on a number of occasions about the same practitioner be taken into consideration when you assessing whether to proceed with the complaint?

Ms Grogan: Yes, of course. The database that Dr Coulson Barr refers to allows us to review all complaints made about an individual practitioner or a health service provider in general, and it is perhaps the first or at least the second step that is undertaken when we receive a complaint. We review, for example, in respect of a practitioner, the complaints history. I think you correctly identified that from time to time we do receive complaints that are made anonymously about certain practitioners and our view of those matters is that in some instances, with the mechanism of making the complaint, the legislation is being used in a way for which it is not intended. For people who have their own issues it might be a personal issue, for example, that they are using the complaints mechanism process for.

We also have the opportunity to review the complaints held by Ahpra, our co-regulatory partner, so we can view complaints that are made in the same way. Anonymous complaints can sometimes be made from colleagues or practitioners who hold very grave concerns about the conduct or performance of a practitioner but they do not feel as though they want to put their name to it; they might be fearful of retribution or reprisal in the workplace. Some of those matters I can think of that we have dealt with fairly recently have been very serious complaints about the conduct of a practitioner where significant regulatory action has followed.

CHAIR: You mentioned that personal and sexual safety is an issue. You also talked about discharge planning, young people and services—you talked about family involvement—and you mentioned that you are outlining a range of strategies in relation to personal and sexual safety. Are you also outlining strategies in relation to those other matters to the Chief Psychiatrist and would you be able to share those with the committee?

Dr Coulson Barr: We have targeted firstly the issue of sexual safety in our discussions with the Chief Psychiatrist. We have a collaborative relationship in terms of consulting on a high range of issues that get brought to our attention. That is the priority focus for our initial discussions. We certainly will cover all of those areas in our discussions with both the Chief Psychiatrist and others in the sector.

CHAIR: Can you share that with the committee?

Dr Coulson Barr: In terms of the outcomes of those?

CHAIR: The strategies that you are outlining.

Dr Coulson Barr: We have just had beginning discussions with the Chief Psychiatrist and we are going to meet together to share what are our current insights in terms of the nature of matters that are brought to our attention, compared to the nature of incidents that have been reported to the Chief Psychiatrist, look at how they marry up, how they align and where the potential gaps are, and then develop a strategy of how we look at sharing that data into the future and looking at how we can track all those emerging trends. It is very early days. I am happy to outline that in a bit more detail, but we really have just had beginning discussions on that.

Dr ROWAN: Dr Coulson Barr, I want to thank you and your colleagues at the Office of the Health Ombudsman because you undertake some very complex and challenging work. My first question relates to the aggregate data you are collecting and the trends, and you touched on this in your opening statement. It is about quality improvement and the ongoing role of education—that feedback loop and that sharing of information with the Mental Health Commission, the various professional colleges, whether they be medical, nursing or allied health, and even with the mental health and alcohol and other drugs branch. How is that shared not only with individual practitioners or groups of practitioners but more broadly across the system so they are involved in that educative work about how things can be improved with respect to communication or engagement on behalf of consumers? Do you have any initial thoughts, given your length of time in the role, on how that could be further fostered and improved in Queensland?

Dr Coulson Barr: There are so many opportunities for my office to engage with those stakeholders—with the colleges, with boards, with groups—in terms of sharing some of the insights and things that we see and the opportunities for how they can inform education. In my previous roles I have had examples of utilising data and themes from complaints and them informing part of the curriculum for the masters of psychiatry course, for instance—where you are engaging with registrars and identifying those key emerging underlying issues around communication, how you can truly have a consumer at the centre of care and treatment and how you can avoid complaints from escalating and developing further. It is really addressing those underlying issues. There are lots of opportunities for that. I am going through a program of engagement with the boards, colleges and services and teasing out those opportunities.

The OHO over many years has had a range of stakeholder engagement in education activities. Post COVID—whether we can say ‘post COVID’—it is looking at a stronger engagement strategy and looking at how we can reset that and have it in a targeted way of what are some of the key contributions we can make from what we see. I think you are right in terms of focusing on that underlying issue of communication. A lot can be addressed if that communication between the patient and the practitioner can be established on a strong foundation from the beginning. That can be foundational to many of the issues that we see.

Dr ROWAN: I have a follow-on question in relation to the triaging process, and this may be a question for Ms Grogan. Often there is a balance when complaints are made, particularly in relation to mental health consumers or patients who might be on involuntary treatment orders or may have compliance with the dispensing of medications if they are on the Queensland Opioid Treatment Program. Individual health practitioners have an obligation to provide care, whereas consumers may have objections to that even though they are under legislative obligations or obligations under involuntary treatment orders, the Mental Health Court and others. I want to get a sense of how those are balanced in the triaging assessment process when complaints are made.

Dr Coulson Barr: I will give an initial response and then I will refer to Ms Grogan. One of the strengths of the OHO’s model is that it is quite an agile response in that people can make verbal complaints from inpatient units. Sometimes it is a very real and present issue in terms of their concern about the nature of their treatment and the medication they are being given. We would assess the current pressing issue and how that could be potentially resolved and addressed or clarified. In this context of treatment, often it is a contested space and it is very emotional, and sometimes the consumer does not quite understand the nature of treatment being given and the basis for the treatment authority.

We would assess the ways of resolving that, and our engagement with the independent patient rights advocates is really critical in that in terms of looking at whether it is something they should be addressing on the ground or alternatively whether it is something we could be engaging on directly with the service in terms of talking directly with the NUM of the service—if there is a pressing issue that could be responded to in an early resolution approach. One of the critical aspects of responding effectively to mental health complaints is that agile response of looking at what is the current pressing issue and how we can best respond immediately, and then how we assess in a more considered way the underlying issues that might sit behind that immediate concern.

Ms Grogan: One of the important aspects is that we recognise the delineation between our role at the Office of the Health Ombudsman and that of treatments being prescribed under the Mental Health Act. Sometimes people come to us because they have a view or a desire that we might be able to overturn an order or an authority that they are subject to. Of course we do not have those powers for very good reasons. That is part of the communication that Dr Coulson Barr is talking about: if we establish that somebody is under the care of an authority, we will encourage them to engage the independent patient rights advisers. Often we will make contact with the independent patient rights advisers and ask them to pop down to the ward to visit the consumer to provide them with advice and guidance on their rights, if they want to seek a second opinion and how they can engage with their treating team about any concerns they might have with their medication.

I think that is a really important role. It is something that we spend a lot of time on in training our intake staff, the people who are answering the phones. We certainly do not want to interfere or be seen to be able to interfere in the therapeutic relationship between the treating team and the consumer or provide information or act in a way that might jeopardise that in any way. Our role is to encourage people to continue to engage in treatment that is necessary for their recovery and wellbeing.

Ms KING: Thank you for coming in today. In my role on the health committee I am sure I will be seeing more of you. I want to ask specifically about what the OHO is doing going forward to ensure that complaints made by people with intersecting vulnerabilities in the mental health system are captured to the extent necessary to address any systemic or individual issues. If a mental health inpatient, for example, is an Indigenous person or has a disability or is a woman or some combination of those issues and more, how are we ensuring their voices and their complaints are being sought out? Is there any proactive engagement in that space? Is there anything you can tell us about it?

Dr Coulson Barr: The first response in terms of when we are receiving those complaints is that the complaint navigator role has been a crucial addition to our response in terms of identifying those people with those intersecting vulnerabilities and how we can best support them through the complaints process. You raise a really critical point in terms of how we ensure that our services are truly accessible to people who face the most difficult barriers to make a complaint. That is certainly a priority focus for me stepping into the role. I am starting that program of engagement with stakeholders, including Health Consumers Queensland. We are looking at the potential of having some kitchen table type consultations in terms of trying to understand people's experiences and the barriers they may be experiencing. I think it is important that we understand who we are not hearing from and why and how we can ensure our processes are supported.

It is also about communities and people on the ground knowing about OHO; it is that broader awareness about what our role is and what our processes are. People can have a fixed view about what making a complaint is and not realise that they can pick up the phone and we can assist them through the process. Getting that message out is really important. One of the areas of focus is looking at what we need to do in that space and what are our approaches to engagement. I would certainly be wanting to speak to the committee over time about our approaches on that.

Ms Grogan: The other quick addition I would make is about the training we provide to our staff. We have a very strong focus on building cultural capability in our staff, particularly in the first points of contact with the complainants. We identify the particular vulnerabilities of people who are culturally or linguistically diverse and we provide an appropriate complaints mechanism or support for them to make their complaint. If they have particular preferences—for example, they may only wish to speak to a female officer because of the particular circumstances of their complaint or their particular beliefs—we ensure that we are responsive and we provide that sort of service to people.

Ms KING: What do we know about the numbers of complaints received and how those match up to particular cohorts within the mental health system? Do we know much about that yet? For example, are Aboriginal and Torres Strait Islander people represented in the complaints received to the same extent that they are represented in the mental health system and so on?

Dr Coulson Barr: That is a key area of attention that we need to understand in more detail. We need to look at how we can share our data in terms of the numbers of complaints that we receive and how that compares to the share of consumers in different types of services and different areas. We have not had that capability but they are the discussions I have been having with Queensland Health—that is, if we can build our data capabilities, we can do that meaningful analysis about the disproportion in terms of the types of complaints that we receive, whether they are represented or not, or whether there are particular groups that we are missing. It is absolutely a key focus for us to understand that in more detail. We have some data but I do not think it provides a meaningful picture because we need that comparator about how it compares to the numbers of people in different types of services.

CHAIR: I want to ask about the complaints based system for the HHS primarily but also the private hospital system. Are you aware of the submission made by Care Opinion Australia? Could you provide any advice as to whether or not the proposals they put forward have any validity? Are you aware of any other systems that have been rolled out around Australian or in international jurisdictions that provide a more robust model of managing mental health service complaints?

Dr Coulson Barr: I am not aware of that submission but I am happy to take that on notice and review it and provide some feedback to the committee. I am not aware of the detail in that submission.

CHAIR: Thank you. Are you aware of any other approaches to managing mental health complaints in other jurisdictions that differ from Queensland?

Dr Coulson Barr: One example would be the Victorian model that I am most familiar with. It has had a dedicated approach to dealing with mental health complaints where the complaints function sits within the Mental Health Act. That is one example. There are many learnings that you can take from that model that can be applied in the OHO response. That is partly the area of attention that I am looking at: what are those success factors that are used in other models that we can apply and build on our strengths here? We have already touched on some of the things in terms of looking at that accessible process—that is, in terms of people's knowledge of being able to use an independent complaints process. I understand that your focus is more on the accessibility and responsiveness of complaints processes of health services themselves.

The OHO has some valuable resources that are currently available to hospital and health services about effective complaints processes. I think that is where we could build more engagement in terms of the key ingredients of effective complaints processes for mental health consumers. That is really building in an agile response in terms of people being able to raise an immediate issue that is more common in an inpatient environment. The length of stay is usually quite short so issues need to be addressed in a timely way.

We also need to think about creating environments where people feel safe and supported to raise their concern. There is a lot of fear and barriers for people to raise a mental health complaint. Stigma is still ever present and it can be a reason people will not raise a complaint while they are within a service. It really requires dedicated attention from health services to create what we would call a positive complaints culture to enable people to feel supported to speak up about their concerns. That is partly about seeing complaints as integral to treatment and care, not as something that is referred off to the patient liaison officer. It is something that the treating team should be engaging with the mental health consumer directly on in terms of how an issue can be resolved.

CHAIR: In my opinion, one of the strengths of the OHO is the capacity to receive complaints about unregulated practitioners, particularly in relation to alcohol and other drug services that are provided by unregulated practitioners. Do you receive many complaints related to mental health services in relation to unregulated practitioners?

Dr Coulson Barr: We certainly receive them. I could not give the quantum. Can you comment on that?

Ms Grogan: I could not provide numbers. It certainly is a feature of the complaints that we receive. They are managed within the protocol of, if it is about the service then the service issues are looked at, what the funding arrangement might be and if there is another entity that we might be able to refer that to to deal with. It is also paying particular attention to the individual practitioners in the unregistered space, to be able to deal with those people if the care and treatment they are providing is inappropriate or inadequate.

CHAIR: Without providing identifying data or information, can you take that on notice and provide us with some more details in relation to unregulated practitioners, also specifically in relation to AOD services?

Dr Coulson Barr: Certainly.

Dr MacMAHON: I note that in your submission you reflect on how specialist mental health care is often not available in crisis situations, which can have really devastating consequences. Can you elaborate on some examples of that? What are some of your recommendations in that space?

Dr Coulson Barr: Karen, can I defer to you to give some examples?

Ms Grogan: We have dealt with a number of issues in this space. Certainly we have seen some impacts, or anecdotally we believe there have been impacts, with the stress and strain that COVID has presented to people. We have seen an increase in the number of complaints where people are saying that services were not available to them or they could not access those services because there were no beds because the beds were all taken up, and the triage process or the priority system at the hospital placed that person's needs below another person's needs, which I think is a much broader issue in terms of resourcing and responsiveness to the COVID pandemic.

We have seen some other challenges in terms of general accessibility in terms of rural and remote access to people and services being able to be provided to young people, so specialised services for children and young people who are experiencing extreme crisis. We note of course, though, that there has been some injection of funds and some additional services have been opened in recent times. This has been a very welcome addition to the suite of services available to Queensland. We have seen some complaints, as Dr Coulson Barr referred to, about sexual and personal safety also of young people in those facilities. That is an ongoing concern that we hold for that model of care.

CHAIR: I would like to thank you very much for your presentation this morning. It will certainly help to inform the committee's work going forward. Thank you for all the work that you have done over the past couple of years during COVID. We appreciate your time here this morning.

Dr Coulson Barr: Thank you for the opportunity.

Proceedings suspended from 10.30 am to 10.46 am.

CHAIR: The committee has taken a trauma informed approach to public hearings where it is hearing from people about their lived experience of mental ill health in a personal capacity. There is a qualified psychologist available to you today should today's hearings raise any issues for you. Please see the secretariat if you would like to engage this support. Alternatively, I would encourage you to seek support through your own network should you need to.

Before I welcome the first in the last group of witnesses we have today, I want to say that at this stage it is anticipated that this will be our last formal hearing. We attempted to start the process hearing from people with lived experience. To that end we went to Stepping Stone Clubhouse and heard from a range of people with lived experience. Along the way we have heard from many people with lived experience and lived experience practitioners. We are now finishing our formal inquiry hearings by hearing from people with lived experience. Hopefully it gives an indication to the community of the value that the committee places on the experiences of people with lived experience of mental health issues, alcohol and other drug issues and suicidality.

LEWIS, Ms Laura, Private capacity

CHAIR: Welcome. Please feel free to make an opening statement and then we will go to the committee for questions.

Ms Lewis: Can my husband place a painting at the front for you to see?

CHAIR: Sure.

Ms Lewis: It is a visual tool for me. It is my art; I have not plagiarised.

In the spirit of reconciliation, I acknowledge the traditional custodians of country throughout Australia and their connections to land, sea and community. I pay my respects to elders past and present and extend that respect to all Aboriginal and Torres Strait Islander peoples today. I would also like to acknowledge people with a lived experience of mental illness, whose stories must be heard. I would like to thank the Mental Health Select Committee for your work and for extending an invitation offering me this opportunity to speak. I also add an additional thank you to my state member, Joan Pease, who encouraged me to email you.

This is a painting that I completed in the previous week to help me write this. I used my creative processes to write this. To create the painting I used twine that is glued on the board to form the shape of a tree trunk growing into one of the many branches that form a tree. The twine, made from individual strands, represents people who fulfil roles in our communities: educators, politicians, P&Cs, sporting organisations, media and groups that represent families. This vital diversity together strengthens and forms the tree trunk. The trunk is community and the branches represent both diversity and intersectionality.

A tree cannot exist without branches but they are all different. Some branches are healthy, with an abundance of life flourishing on them. Some may have birds' nests, possums and insects that are part of the ecosystem. Some may not have nests or possums but they are vital to the tree as they are veteran branches with many offshoots. Some branches are twisted and scarred but fulfil their role in helping to collect sunshine and hydrate the budding young shoots in the very upper canopy. Every branch is vital to the health of this tree—this community.

On this branch in my art you will see a bird's nest made from used and blackened matches, which depicts trauma I guess. It has holes and twigs missing, signifying gaps and barriers felt by parents with a mental illness. Inside the nest are two perfect eggs and they are gold. They represent hopes and dreams, which include meaningful work, travel, friends and lifestyle because not all people with a mental illness have children. For me, the eggs represent my two children and they sit unattended because, as a parent with a mental illness, I am caught in a cycle of tending to the nest or systems, which distracts me from protecting my eggs and exhausts me and makes me unwell. If the eggs hatch then they will also be vulnerable and easy prey.

The tree trunk and its branch support the nest but provide no scaffolding or physical or emotional support to my family, and sometimes we feel quite isolated. There is a faint gold canopy that does not quite reach over the nest. This canopy provides shade to community—community that wants to understand mental illness, community that are not intentionally cruel but are scared of the stigma that exists and choose to avoid awkward discussions. The nest, with a mentally ill parent, never quite enjoys the shelter of the canopy or the community.

My first exposure to mental illness was when I was diagnosed with postnatal depression. My firstborn was six months old and we were living in Mackay. I felt something was off and I felt incredibly guilty that my perfect baby was not making me happy. I was feeling feelings that I did not understand.

I actually flew back to Brisbane to see a GP I had been seeing for years because I trusted him. I saw him once—just one appointment—and all I received was a prescription for an antidepressant. He did not discuss with me any kinds of options that could include mindfulness or seeing a psychologist. I did not know at the time that that should have been a suggestion or a conversation that was had.

We rely on our GPs, no matter what kind of conditions we have, to be a good resource for many things impacting our health. Wondering if the catastrophic breakdown that I experienced nine years later could have been avoided is something that I do a lot. Of course, I have no way of knowing if this is true. A lot of the treatment I experienced from 2011 I cannot discuss in a public hearing without the protection of privacy and confidentiality. It is impossible to provide feedback on institutions that represent shareholders over my own interests. My diagnosis of depression in 2011 was a misdiagnosis. This misdiagnosis led to me being told that the only treatment available was electroconvulsive therapy. It is invasive, traumatic and left with me an acquired brain injury. I have a short-term memory impairment that is still denied by my then treating clinician. I never had that debilitating condition prior to ECT.

I received a diagnosis of autism and ADHD at 50, which was liberating and painful due to examining many historical events in my life. Those ‘aha’ moments are bittersweet and, as someone who has been involved in much advocacy over the years, I have learned to speak up for myself. However, it is very difficult to receive person centred care because the imbalance of power with our clinicians is incredibly unfair and our diagnoses are used against us.

In my career as an unpaid advocate I have spoken in Parliament House, Canberra. I have given testimony to the Senate Select Committee on Autism. I have stood on the TEDxBrisbane stage and provided a one-minute pitch. I have attended and spoken at countless events around mental illness, autism, disability and inclusion. Despite those achievements, my treating clinicians ignore my requests to use acceptance and commitment therapy. This makes me feel unheard, disempowered, disrespected and that I am inadequate—too inadequate to be involved in decisions about my personal choice around my treatment.

I would like see a far less pathologised approach used for treating people with mental illness. I would like to see more people living with a mental illness speaking at events that target us yet usually talk at us. I would like to see our child youth mental health services accept children as clients. I have also been a previous parent/carer member of the advisory group for CYMHS, some time ago. I acknowledge that they do good work, but they are stretched with their budgets.

Autistic children have mental health conditions. I would like to see the funding allocated to headspace improve so that their staff retention improves. I hear great things about headspace, but the frequent issue I hear from people in the autism field mostly is around the high staff turnover. That is problematic for autistic young adults as they need continual routine and things to be the same. I would like to see mental health nurses working in hospitals receive trauma informed training because they talk to us like we are children.

I would like to talk about the NDIS. I have a 20-year-old disabled son. He has a support coordinator and is plan managed yet my involvement in his very adult life and navigating the NDIS is essential. My own disability ensures my ability to effectively do this for my son is compromised. I have had two hospital admissions due to stress induced by a scheme that is intended to support my family member. This failing has meant I have also yet to access the NDIS myself.

In 2011 I had seven admissions, which was a combined total of 163 nights away from my young family. I continued to have admissions past 2011 but they were less frequent. I attended day programs, working hard on building a toolkit of resources. The very best learning was my own realisation last year that I have survived 100 per cent of my difficult times. I have learned to allow myself to sit in discomfort knowing that I will get through it. We pathologise negative feelings. We are medicated to avoid negative feelings. We are taught CBT to challenge negative feelings. My lived experience realisation of understanding that negative feelings, while painful, are survivable has been far more helpful than 11 years of many different treatments.

We have come a long way, it has to be acknowledged. My great-aunt lived in an asylum in Victoria and endured shock treatment with no anaesthetic, but we still have so much to learn and implement. I recently attended a symposium with a vast number of people with lived experience in the audience. Again, we were talked at; we were not included. We were not standing on the stage. There were some people standing on the stage, but they represented NGOs and they held high positions, and I cannot say because it might identify them. We need independent people also standing on that stage, telling our story of lived experience, storytelling and being a part of co-design of any implementations that are being considered. I feel rage and sadness. I feel scared of a relapse and I will avoid a hospital admission at all costs. I do not feel heard. I have not seen my psychiatrist since October last year.

I am heavily involved in a wonderful initiative which is based in Queensland but is Australia-wide and it is funded by the department of services. It called the Finding North Network. This network is exclusively for people living with a mental illness. This network brings us all together with many different lived experiences and beliefs, yet we all get along really well. I am not my mental illness. I am not disordered. The only mad thing about me is the anger which drives me to talk openly and attempt to improve systems. Thank you for listening.

CHAIR: You mentioned that there were things that you did not want to share in a public hearing. We can go into a private session if there is further information you want to share with the committee and that would stay confidential to the committee only.

Ms Lewis: Yes. I would need time to prepare, though, because I did not put it into writing. That is entirely up to the life cycle of this committee, I guess.

CHAIR: In that case, I will go to the member for Pumicestone for a question.

Ms KING: Thank you very much for coming in. Thank you for what has very evidently been a long career of advocacy in speaking up for people with mental ill health. I have a couple of questions coming out of the things you have spoken about so far. You talked about your desire to embark on acceptance and commitment therapy and how that is not being supported by your treating teams. Would you feel comfortable telling us any more about that in what is meant to be a person centred treatment?

Ms Lewis: I am very attuned because I have done so many day programs of different therapies. The minute CBT techniques are brought into therapy, I say, ‘I do not like CBT. It is really not helpful for me,’ and they dismiss my preferences. I have said that since learning of my autism—I am familiar with autism because my son is autistic; he is 20. I have been an advocate for him and his rights his whole life, so I know a neurodivergent brain will respond differently—not everyone’s neurodivergent brain but mine. I had also had a fabulous mental health nurse—I do not even know if the program still runs, but it was a home visit—a visiting nurse. She visited me weekly or fortnightly for several years. She used acceptance and commitment therapy which is how I first came to understand it. I really flourished under her care. I was devastated when she retired. She could not clone herself!

Ms KING: Selfish!

Ms Lewis: I know!

Ms KING: Can you explain, for my benefit at least, what is acceptance and commitment therapy? I have heard about it, but I do not know a great deal about it. I would love to hear your take on why it is useful for you and your neurodivergent mind?

Ms Lewis: Well, I have read the book by Russ Harris, *The Happiness Trap*, and my takeaway from that was about being present and living just in the moment and recognising that in this moment I might feel really bad but it does not mean that that is permanent and that my next moment I might feel differently, or the next day when I wake up. I really spent a lot of time last year after I decided I could no longer see my psychiatrist—and, again, that is stuff I cannot talk about here—but I reflected on what I wanted to achieve and what was really hard about my mental illness. Most of it was discomfort. I think it is the same as when you have a baby: you are terrified at first and then, the second, you know you are not going to die—usually. I welcomed that discomfort into my life. It was not invited, but I learned to understand that it is a part of the whole gamut of emotions that humans must experience.

Ms KING: We have heard a lot through this committee about lived experience mental health peer workers. It strikes me that your own work and experience in a voluntary capacity may at times have encountered that space. Have you worked with any mental health peer workers through the course of your experiences with the mental health system? Do you have any comments to make about it?

Ms Lewis: I actually did not know there were mental health peer workers available to me. It has never been brought up until, funnily, I was talking to someone very early this morning who lives in Canberra and says that they are available both through NDIS and outside of NDIS. However, I would like to also say that as a person who is a layperson, I have not done any training. I make it very clear to anyone I talk to, whether they are a friend or when I am speaking, that my advice is not professional, that I have taken on a role of almost being an informal peer worker with people who I know are dealing with mental health crises because I never will ignore a call for help; I will always reach out.

Dr MacMAHON: Thank you so much for joining us today. I wanted to ask about your late-life diagnosis of autism and ADHD. My office has been receiving a handful of queries from people about the cost and the time. I wonder if you could just share that experience.

Ms Lewis: Yes, it is a pretty deflating experience. I think the waitlists are really long and the costs are prohibitive. I pretty much got a diagnosis from my psychiatrist but refused to go through the actual testings that I would need to access NDIS because I find the concept of talking about deficits about myself incredibly traumatic because, for 50 years, leading up to knowing I was autistic, I was a living, breathing deficit. At school I did not fit in, I did not belong, I said the wrong things and I misunderstood. I recently read all my yearbooks from high school. I was never a popular kid at school but I always thought that I was friends with everyone. I read some comments and they were not actually nice. It is completely different to my memory of high school. I was like, ‘Oh, wow! That is a bit confronting!’ and I just threw them in the bin.

I always felt different. I knew I was different and sometimes, I have to say, my coping mechanism was, ‘I must be special,’ particularly when I was a very young child—‘I feel different; I must be special’—because otherwise it was, ‘I feel different; I must be broken.’ I did feel both.

It is incredibly difficult to access as an adult. It is very expensive. We also do not have enough people in the mental health industry—I think it is only psychiatrists in Queensland—who can diagnose adults. I do not think there is enough awareness and understanding. I had to say to my psychiatrist, ‘Can you please go away and read about the prevalence of late-diagnosis autism and ADHD in women?’ To his credit, he did do that, and I really appreciate that he did that.

Dr MacMAHON: You mentioned before institutions that are beholden to stakeholders over individual care. I think you were talking about private healthcare institutions. Could you elaborate on that a little bit?

Ms Lewis: They call us ‘consumers’. With 11 years of admissions, which dwindled—the frequencies slowed down and dwindled across the 11-year span. I cannot quantify it right now, but I can tell you that there has been cost-cutting, and the ownership of the hospital, I think, has changed a couple of times and is foreign owned. I find that there is a lot of conflict when it comes to the care of a very vulnerable person. The CEO answers to the board who answers to the shareholders, and that is just a quandary.

CHAIR: Going back to your yearbook issue, I think everybody on this side of the table would say to you, ‘Don’t read the comments.’ Never read the comments! I wanted to ask you about the Finding North Network. I have just looked it up. It seems to be run by the Mental Illness Fellowship of Australia.

Ms Lewis: Yes, MIFA.

CHAIR: MIFA has given evidence to the committee. Can you tell us a little bit more about that network and how it helps you?

Ms Lewis: The network has an app where we can all access and interact with each other. There are groups; I am in a Mad Pride Group. It is still under development, but there they are going to be adding extra features where you can upload articles of interest and things like that. I find that they post a lot of opportunities to apply for work within the mental health sector as lived experience people, and to attend events. Because I am an independent advocate I will not work for an NGO, because the moment you work for an NGO you have a conflict with where you get your government funding from. You cannot really criticise it openly.

One of the highlights for me was when I was invited to be a part of a presentation to the department of services. We had 47 department of services staff dial into the Zoom or Teams meeting. In my wildest dreams of advocacy, getting face time with one influential person—a CEO or a politician, anyone who can help or listen, or be part of change, is really hard. You have to work really hard to get it and usually you do not. I had 47 people listening to me. I was highly recommending Finding North Network, but I also was very aware that they can take that funding away at any time. I did not give anything false. I did not say anything because I wanted to see them continue to receive funding, but just that opportunity to speak in front of 47 people from the grants section of the department of services was cool, and it helps with your confidence, too.

These opportunities Finding North gives you help you understand and realise that what you have to say is worth saying and worth hearing. We have members who have very firm faith based beliefs around their recovery and we have people who like to use the word ‘recovery’. I do not like to use the word ‘recovery’ and we all just talk about it in a way that is very respectful and we learn from each other on how it works for them and why they like that. It is moderated really well. The project leads are very good as well.

CHAIR: Unfortunately, we have run out of time. I want to thank you for taking the time to come here, for showing us your beautiful artwork and explaining the significance of it to us. The evidence and the stories that you shared with us today will certainly inform the committee’s work as we go forward. Thank you very much for coming in today.

Ms Lewis: Thank you.

Mr MOLHOEK: Laura, thank you. I absolutely love your painting and I am blown away by the story. If fact, I slipped over a note to say we should capture an image of it somehow.

Ms Lewis: You are welcome to take a photo of it. I am happy to supply a text of the process of painting it and what was going through my mind. That is fine. I am going to be entering it in the Mental Health Awareness Month—it is in October—Recovered Futures Art Exhibition. If it is chosen it will be exhibited at City Hall.

Mr MOLHOEK: I think we should exhibit it here at parliament somewhere.

Ms Lewis: You are very welcome to do that too.

CHAIR: We would have to take that up with the Clerk and the Speaker. Thank you very much.

NELSON, Mr Darryl, Private capacity (via videoconference)

CHAIR: Mr Nelson, we have read your submission but you are welcome to make an opening statement if you would like and then we will go to the committee for some questions.

Mr Nelson: My name is Darryl Nelson and I am a victim of forced adoption. I was born in 1964 in Boothville, the Salvation Army mother and baby home in Windsor, Brisbane. I was classified unfit for adoption and placed into foster care for two years. In the meantime my birth mother and father got married but the government did not tell them that I was in foster care and they did not tell them of their rights to access. In the meantime, they had a baby who died, unfortunately, at birth. I was still in foster care. The government then adopted me—wrote an adoption order. I was adopted without my father's consent, even though they were married and that legitimised me at the time.

I found out that I was adopted around 14. I guess I have had lifelong mental health issues caused by the adoption. I have seen several psychologists over time. I think it is compounding over time. I am only becoming aware of the things that happened to me. For example, I did not get to meet my birth mother. The laws prevented me from finding out where I came from for 30 years and then she died, unfortunately, at 30. I never knew her. I did meet my natural family. I found out I have two full brothers and a half-sister. Since I was about 30 I have tried to forge a relationship with them and that has been going okay except they live in Queensland and at the moment I live in Sydney. It is a work in progress.

CHAIR: Darryl, you said that there has been a lifelong impact on your mental health as a result of the forced adoption. How have you found the experience of being able to access support and care when you have needed it during that time?

Mr Nelson: I think it has been quite limited. I did not really know what I could access until recently—maybe in the past five years. Before that I had to go it alone. I sort of was not aware. I did not make the tangible link between adoption and how I was feeling. It took a long time to come to a realisation of where some of these thoughts were coming from. Once I accessed that help it has been helpful. Jigsaw Queensland is one of the various places where I seek support. That is really for counselling only, though. For deeper psychological support I tend to have to employ or seek services that I pay for through psychologists et cetera.

CHAIR: You said you became aware of your adoption at the age of 14. Was the actual process of finding out quite traumatic at the time or subsequently? Do you feel that that has had a lasting impact on you?

Mr Nelson: I think it was. At 14 you are going through puberty, which is about identity, right? I was basically handed a piece of paper, which was the adoption order. I kind of uncovered it after many times asking, 'Am I adopted?', 'Am I adopted?' I did not really fit in. I did not think like my parents. One particular time I asked and my mother started crying and said yes. Then she gave me the piece of paper and I was left alone with that piece of paper. There was no support at that point from the government. I was just left to deal with it. At that stage of my life the choice I had was to leave this family that had lied to me for 14 years or stay and do what I could. That is what I did: I stayed. I chose to be obedient and fit in and adapt, I guess, as adoption is adaption, right?

I continued with that and kept going until around 22 when my adoptive father died. I felt that gave me a bit of permission to try to understand more about myself. Around 27 and 28 is when the laws changed and I could actually write away for some information, which I received at around 30 years old. It had a lasting impact, finding out like that. Now we talk about open adoption where children are told early on that they are adopted et cetera and that they can actually meet their real parents, and I think that is helpful. It seems to be helpful.

CHAIR: Until recently the adoption loss support service was located in my electorate. That organisation supports people like your parents, I guess, who were subjected to having their children forcibly adopted. I have heard your story from a parental perspective before and it is pretty harrowing stuff. Thank you very much for sharing with us today.

Mrs McMAHON: Darryl, I admit that I do not know too much about the historical adoption practices in Queensland. Could you step through it from your understanding? Obviously you have done a bit of research and a bit of work on the circumstances around your forced adoption. Are you able to share with us the circumstances of your birth parents at the time and what they went through? What was the process for them? What was the role of that Salvation Army home and the role of the government at the time?

Mr Nelson: Sure. I will try to keep it short, but I know an awful lot now about that. Basically, my birth mother was forced by her mum to give me up. There was some doubt in my grandmother's mind about who the father was. My mother had no doubt; she knew it was her long-term boyfriend.

He had recently gone to Mackay to learn a trade so they had been separated, but she used to visit. I was conceived in Mackay in 1963. When she started showing, her mother sent her away to Boothville, the Salvation Army hospital, and they interred her. In other words, they put her in there and she could not leave. You were trapped. They dressed you in a certain uniform. You had to work. You might have heard of the Magdalene Laundries. It is similar to that, where they have to work for their keep.

Once she gave birth to me I was separated from her. There was that, I guess, abandonment. The government then classified me an orphan. Basically, once she had signed a consent to adopt, which she was pressured to do, I was classified an orphan. The father was never contacted. In those days they did not have to do that. In fact, they did not have to put the father's name on the birth certificate. I was separated from her for two weeks in hospital. Typically these women are given drugs to stop lactating. Some of those drugs have side effects like cancer.

Within the two weeks a doctor saw me. Because of a story that my grandmother believed that there was a rape by my mother's cousin, they assessed me as being not fit for adoption because of the close parental relationship. However, my mother named me after her boyfriend, Allen. That was spelled A-L-L-E-N, which is a surname and unusual as a first name. That was my first real link to finding out who he was. They separated us, and I would have been placed into institutional care except that there was a foster family waiting for a child and they took me in. They did not want to adopt at the time; they just took me in for foster care. Like I said, in the meantime my father had come back from Mackay. He met up again with his long-term girlfriend, my mother. They got married and I was still in foster care.

Mrs McMAHON: Darryl, just going back through your story, what was the age of your mother? Obviously she was either compelled or forced to give up you and her legal rights. Can you confirm that your birth certificate did not name a father?

Mr Nelson: That is right. My mother was 21 years old when she gave birth to me so she was not young. She had the legal right, I believe, to consent, although it was not informed consent. When you are adopted they give you your original birth certificate. My father's name was not put on there, even though she had declared who he was. One of the reasons they say that they do that is because they did not want any complications with consent. They had the mother's consent to adopt. They did not have her consent to place me into foster care, though. She did not know that I was put into foster care. Does that answer your question?

Mrs McMAHON: Yes, it does, thank you. In connecting with your natural family, did you get any inkling or insight into the trauma that that process had on your parents?

Mr Nelson: I think the first sign of trauma for me for them was the fact that she died so young. She died at 30 years old from a brain haemorrhage, or stroke I suppose you could say. A stroke can be caused by many things including stress. There was talk about her being quite unhappy. Even after they got married this manifested over time and she had health issues.

With my father, I met him when I was 30. He had tried to find me before but could not because the laws prevented that. When I rang him up one day after a lot of detective work, because the government did not tell me who he was, he seemed very happy, but he is a very closed man. It is very hard to tell what effect it had on him. He has said that it took a piece of him away from himself, if that makes sense. I was his firstborn son. My mother was too ashamed to tell him what happened to her until after they got married and after Lawrence died. Then she said, 'This is not your first son. I gave away your first son. He is adopted.' Because that is what they believed, they never went searching for me because they thought once you are adopted that is it. The fact is: I was not adopted then. I was still fostered.

There was a duty of care that the government had written into legislation talking about the best interests of the child as the paramount consideration in adoption. This duty of care was not considered, I think, on my behalf because I had a ready-made family. I had the married mother and father. I could have gone back to the original birth family. That was never considered, never investigated. Instead they put me into another family.

Mr MOLHOEK: Darryl, thank you so much for coming and sharing your story. I have had some lived experience in that I have a number of family members who were victims of forced adoption whom we have since reunited with and it has been a very positive experience, largely. We have discovered I have a whole lot of great-nephews and—nieces that I never knew previously. I am interested about your actual adoptive family. I think you said earlier that you never felt quite like you fitted in and in your email cover you talk about having been abused. I am interested to hear a little bit about your experience with that adoptive family. I have heard very positive stories about adoptions and adoptive families, but it sounds like the family that adopted you were not all that kind.

Mr Nelson: I think my mother, Jean, loved me for sure. My father, I think, was a bit indifferent to the whole circumstance. I think he did his bit, what he could do. He was not really a man of emotion. He was a violent man and I felt the wrath a few times. My mother was very caring so there were not any issues with her. I think for me I sensed that I did not fit in. I sensed that there was no—it just did not feel right. It is hard to explain. They say that there are remembered and recalled issues from babies when they are relinquished, when they are separated. They still remember their mother; they remember their mother in utero. That carries into being a child.

I think the first taste I had of my father's wrath was when I was around nine years old, when he broke my nose in a rage one day. Unfortunately, as it turned out, that was around the same year my birth mother had died. It is funny, these coincidences. I was wary of him, and our relationship after that time was not close. He liked other things. He was good with his handiwork, with wood and metal and things like that, and I was never interested in things like that. I was interested in art. I was a cartoonist; I liked to draw. Although my mother supported me through that, they never really understood how I thought. I did not understand how they thought.

We moved around an awful lot because dad was sick: he had asbestosis. We did not know at the time but he could not work so ended up caretaking on a number of different properties around New South Wales because we could get free rent. I never had a stable, I guess, foundation in my childhood. Even when I found out I was adopted, I was in a place called Hobbys Yards, which is a one-horse town in the back of nowhere near Blayney in New South Wales. I just felt like I could not escape from there. I did not identify with how they thought. When things happened to them it seemed like they just happened. They never made a decision. If some circumstance happens to you, you would like to think that you can go, 'All right, well, that has happened. What are our choices? I have a say in what happens to me going forward.' For them it was almost like they were blown by the wind. Having never had a stable foundation and not looking like them—having no genetic mirroring, I suppose, and no extended family around me; it was just us three, and I had very white skin and they were tanned—I thought something was fishy, and when I finally discovered I was adopted it made sense to me.

Ms KING: Thank you so much, Darryl, for your really considered and detailed submission. I want to acknowledge the impact of forced adoption practices over a long period of time on you and on other people who have experienced that as well. I was really interested to find in a previous piece of work relating to termination of pregnancy that it is considered that adoption as an outcome of unplanned pregnancy actually has very poor outcomes for parents and for children. That is something that has been researched and considered. Given that this happened to many people—I know a number—I wonder if you have engaged formally or informally with any of the networks that exist for people who have been part of forced adoptions to support each other and if you have found assistance through that?

Mr Nelson: Yes, I have—only recently, though, in the last couple of years. What happens over time is the government progressively released certain information. When I was 30 I was able to get identifying information, which basically gave me my mother's name. Then through my own research I found my father. Decades passed, and it was not until I think a few years ago that I found out about my foster care and the fact that my parents were married whilst I was still farmed out. The point I am getting to, I think, is that, because this information comes over time and you deal with it in segments, I also had to try to digest the fact that I was given away even though I had a family. That awareness only came about a couple of years ago. Then I started researching. Prior to that I had not had any contact with any social or support networks, really. I knew of Jigsaw and other groups, but because they were funded by government in part I always felt very wary of them and obviously I thought they were biased so I did not really engage with them.

Once I had as much information as I could get then I started to go, 'Okay, I think I need support here,' and I undertook a discharge of my adoption. I found that information through ARA, Adoptee Rights Australia, which is an adoptee network in Australia. The fact that you could even discharge was not advertised. I did not know about it. Many adoptees do not know about the fact that you can actually discharge your adoption, although it is a horrible process to go through. You have to go to the Supreme Court. You have to present a case. You have to talk about the exceptional circumstances that qualify you to get your discharge to happen, which usually means you have to outline your mental health issues caused by adoption. That is where the submission that I put to you guys came from: a report for that discharge. I had to fund my own discharge.

I had to go to court, front a Supreme Court judge and ask for that discharge. I got it. Many people do not. Many people cannot afford to. One lawyer quoted me $140,000 to do that. I did it myself. Many people do not have the fortitude to do that. Through that process, which took 18 months, I started to engage with various people, usually through Facebook, strangely enough, and on those different networks you find all types of adoptees—that is, the damaged adoptee, the angry adoptee—and sometimes that is not good for you, either. Yes, you get support in seeing there are other people in your circumstance and you see their anger and go, 'Yeah, I feel like that,' but sometimes when you are having a good day it is not good to engage with that kind of network.

I have done what I can to help other people. For example, I put myself out there and said, 'If anyone wants a discharge, I now know how the process works in Queensland.' It is a long and lengthy process full of pitfalls. In essence, it livens up all your mental health issues anyway, going through the process. I have also tried to write a book to help other people navigate why legislation created over time had resulted in this, affecting thousands and thousands of people like me. I did not ask to have PTSD, depression, suicidal ideation, nightmares. I did not ask to have my relationships over time with women break up because I cannot get close, because I self-sabotage. I did not ask to have rumination of obsessive thoughts all the time. All these things happened to me because of what happened to me which I had no control of, had no consent to. I know all the facts. I think I can navigate a way forward, but it will never leave me, I think. I thought the discharge would alleviate a lot of the identity issues, and it has, but there are still lingering issues. I just cannot come to terms with the injustice.

Ms KING: What could the mental health system broadly do to be more responsive to the issues that people who have experienced forced and maybe even non-forced adoption encounter?

Mr Nelson: I think part of the apology by Campbell Newman and also by Julia Gillard—I think the idea of that apology was that it helped a lot of people. There has been redress for the stolen generation. There has been redress after the Forde inquiry in Queensland for people who were called the forgotten Australians. There has never been any redress considered for adoptees. I am not saying that money fixes anything. It makes governments think, though, before they act. If they have to pay compensation or something later on, they may not do it again. I noticed in Queensland just recently the option of adoption has come back, even though they said that would never happen. Recently in new legislation it is still a preferred method of dealing with social problems. Redress is one thing I think after the apology. It has been nine years since that apology. I do not know why the stolen generation are considered more worthy. It has happened to us the same way—not that it is a competition.

With mental health specifically, I have to fund my visits to the psychologist. That is over 150 bucks every time. Even though I am on a mental health program and subsidised by Medicare, if I want a dedicated psychologist that costs me a lot of money. A lot of people cannot afford to. Perhaps one of the ways to do that is to recognise that adoptees need a different type of support. With the psychologists I talk to, half of my time visiting them is education because they have no training in adoption—little training, I should say. Many psychologists just have general separation or abandonment type training; they do not understand the wealth of issues that are compounded in adoptees. Maybe that is another way to help too. I think support by way of financial assistance. I am still quite indignant at the fact that I have to pay for this. Do you know what I mean? It seems like I am doing all the work here. Yes, the government has apologised and they have moved on, but the remnants remain.

CHAIR: Is there any research or data that demonstrates some sort of a linkage between people who have undergone forced adoption and poor mental health outcomes that you are aware of?

Mr Nelson: I think I am aware of some in America. I can look it up for you guys if you want. The trouble is that once you are adopted you are off the books. Does that make sense? You are now no longer a problem for government; you are a problem for that adoption family. There is an interesting book called *Primal Wound*. Nancy Verrier is the author. I think she was the first psychologist in America to start writing down some of these effects on adoptees. That is a good book to look at. It seems to be the bible for adoptees. There is some limited research in America about this, because once you are adopted you are no longer an adoptee; you are part of that family legally so you are off the books and you are not followed up. When you are in foster care the government visits the family every few months, I imagine. Once you are adopted you are no longer part of the system so the data is not tracked. Therefore, it is very hard to research adoptees when they are no longer considered part of the system.

CHAIR: On behalf of the committee, I would like to express our deep thanks to you for sharing this. We make you aware that there is psychological support available if you require it, if this has created any issues for you from today's hearings. We made the difficult choice of who to call in to talk about this issue. There are many people who contacted our committee and made submissions who have gone through similar experiences. Your submission and your presentation here today will certainly inform the committee’s work and thinking going forward. Thank you very much for your time.

Mr Nelson: Thank you, committee.

Proceedings suspended from 11.48 am to 12.20 pm.

PATTISON, Ms Mia, Private capacity

CHAIR: I remind you as a witness appearing in a personal capacity that if today's hearing raises any issues for you to please seek support. We do have a psychologist available to provide support after the session if that is required. Welcome. Thank you for taking the time to come and present to the committee today. We have received your submission, thank you. It is an excellent submission. I would ask you to make an opening statement and then we will go to the committee for questions.

Ms Pattison: I begin today by acknowledging the traditional custodians of the land on which we meet today and pay my respects to elders past, present and emerging. I would also like to thank the chair and committee for inviting me to talk with you all today. My name is Mia Pattison and I am 26. I have chosen to appear at the hearing today because our current mental health system is failing patients. I believe that as a community we have an obligation to improve the very system that is meant to help people.

I have had contact with all stages of the Queensland mental health system since I was around 14. Across all stages of the system—primary care, the missing middle, crisis care—there are common problems, being: access, which encompasses not just wait times but those who are considered too complex for some services; expense; over-reliance on patients to find their own support; under-resourcing of all stages; lack of alternative options to the standard clinical model; stigma and discrimination by healthcare professionals; and lack of integration of services. The consequence of these problems depends on whose perspective you look at it from. From a patient's perspective, the consequences of these problems result in patients feeling helpless, confused, angry, sad and alone when accessing mental health services, with an overwhelming feeling that when they are at their most vulnerable and ask for help they are turned away, dismissed or left in a state of confusion.

To use the national messaging of 'just ask for help', we actually need to back it up with help. This help also needs to be helpful and not harmful. Sometimes when I got help it was harmful to my personal recovery, with my experiences of crisis care in hospital often leaving me with additional trauma. These experiences are of fear, threats, being overmedicated and watching other patients being restrained and secluded. My experience with these practices is not unique and, even though the national focus is on least restrictions since the Mental Health Act 2016, we know that restrictive practices in Queensland have actually increased. Currently, our mental health system means recovery relies on whether you can afford it, if you are lucky to get a short wait, if you are not too complex, if you are lucky to get a compassionate healthcare professional, if you are sick enough or if you are suicidal enough. We can all agree that luck, wealth, and complexity and severity of illness should not be defining factors in recovery.

The positive experiences I have had with the mental health system have been when services have been accessible, compassionate and respectful. Moving forward, I believe this is how we can address the issues the mental health system is facing. Accessibility can be addressed through adequately resourcing all stages of care, filling the current need for services with community services and peer workers, ensuring there are more freely accessible services and also providing alternative options to the ED such as safe spaces. Compassion can be addressed through further training for health professionals on stigma and discrimination, valuing patient perspectives and patients having more say in their treatment, and more investment in peer support services and patient advocates. Respect can be addressed through further training of staff in crisis spaces on de-escalation tactics, a dual-response model to police responding to mental health crises and patients not being turned away for being too complex. We are at a crucial point in time when we have a chance to change our mental health system for the better and as a community we have to take this chance.

Mrs McMAHON: Mia, I have gone through your submission. As you have said, you have run the gamut of Queensland Health mental health services. From the outset, how many interactions do you believe you have had with Queensland Health mental health services over your lifetime?

Ms Pattison: At which point of care are you talking about?

Mrs McMAHON: Let's talk about hospital admissions.

Ms Pattison: That is a good question but one that I do not know the honest answer to. Probably I would say at least eight that I know.

Mrs McMAHON: Would they have been self-admissions or were some of them involuntary admissions.

Ms Pattison: Some of them were involuntary, yes.

Mrs McMAHON: Could you talk us through the mechanism of your involuntary admissions? Were they police, ambulance, parents, JEOs?

Ms Pattison: Police mainly, so it was an EEA and then an ITO. Then you rock up to the hospital. Generally what happened when you got to the hospital was another patient would say to you, 'Well, are you a voluntary patient or an involuntary patient?' You would kind of look at them and say, 'I don't know.' They would be like, 'Well, did you come with the police or did you come by yourself?' Generally, from a patient's perspective, if you came with the police then you were an involuntary patient but if you were not coming with the police then you were a voluntary patient. I also feel I probably should have known that myself, whether I was voluntary or involuntary. It should not have been up to me to ask someone else.

Mrs McMAHON: I am asking because you make an interesting remark in your submission that whether or not you are admitted depends on whether you are suicidal enough and the determinant of that. From a layperson's point of view, one would think that if you were suicidal or had ideations then that would be sufficient. However, it is your experience that it is not, that there is some kind of tier or threshold?

Ms Pattison: Yes, absolutely: 'We don't have enough beds.' If you do rock up to the front desk and say, 'Hey, I'm here because I'm feeling unsafe and I'm feeling suicidal,' it depends on what your level of risk is, I suppose, as to whether you are going to be admitted into care.

Mrs McMAHON: You mentioned safe spaces. We have heard from a number of organisations that have advocated for safe spaces or a tiered level of facilities in the community. Are you familiar with those? What might your journey have looked like if we had those funded safe spaces in the community as opposed to hospitals?

Ms Pattison: Potentially more therapeutic in that, at that point of crisis, hospital admissions are not necessarily always that therapeutic for a patient. We know that they are often quite traumatising and they are quite uncomfortable. Potentially, safe spaces could have actually given me the skills I needed so I did not need to turn up again. Unfortunately, for example, I never actually saw a psychologist on any of my hospital admissions, and that is quite common. You actually just see a psychiatrist who gives you medication. During that time, no-one is actually giving you the skills that you need to be able to deal with crisis again. Safe spaces could give you those skills to be able to deal with a crisis again. In a hospital space, I think sometimes the quick go-to if someone was feeling quite distressed was to give them medication, and that does not give anyone skills to then deal with a crisis later on. Essentially it just tells them that they dull their feelings by doing that.

Mr MOLHOEK: The member for Macalister asked my question. I was keen to explore the comments you made around more beds. We visited mental health units around some of the hospitals. They are quite sterile and I would imagine that being admitted there would in itself, as you have touched on, be quite traumatising. I was interested in whether you had a view around community based hubs. One of the organisations we heard from yesterday talked about smaller centres in the community where there might just be five, six or eight beds—more of a step-up step-down facility in the community. Do you think that would be better?

Ms Pattison: Yes, definitely. I think at the end of the day it is a really complex problem, that crisis care, and it is not just a problem of not enough beds. I know that I said in my submission that if we just chuck more beds into it then the problem will be solved. I think they are often very sterile environments—often quite scary, for want of a better word, environments. I think we need to view it as, 'Are we giving these people the skills they need to be able to go back into the community?' and, 'Is this approach effective for them to be able to not return here?'

CHAIR: You mentioned in your submission that you first started experiencing mental illness at the age of 14. Did you have any hospitalisations at that period?

Ms Pattison: Yes, I did. I was quite unfortunate at that period of time. As I said, I was very lucky. I am very privileged to have a family that supported me and I accessed a private psychologist for a little bit of time there, but I continued to travel downhill and I also was prescribed some medication. We know that sometimes, in a very rare percentage of cases, when we prescribe medication to people who are depressed they become more at risk, and I was that very rare, very unfortunate case. That is how I ended up in hospital at 14.

CHAIR: Was that a public hospital and were you under the care of Child Youth Mental Health Services?

Ms Pattison: I should clarify: I have only ever had one private hospital admission and it was for a week, but I have mainly always been at public hospital admissions, yes.

CHAIR: Can I ask what your experience was of moving from the child youth mental health system to the adult mental health system?

Ms Pattison: When I came out of hospital, I suppose that is when Child Youth Mental Health Services are kind of following up that kind of thing. At that point we chose not to continue down that route. I do know from other patients that it became very difficult for them when they were on that verge of 17 or 18 because they did not know how to access care. Often they were considered too complex for headspace but, unfortunately, when they turned 18 their CYMHS worker was not able to work with them anymore. So, yes, I think that was really tricky. It meant that often they would receive support maybe for two months after they were released from hospital but then they did not know where to go to next. They did not really have a clear direction on it. I do not have that much experience with Child Youth Mental Health Services, but that is what I saw of other patients.

CHAIR: Can I ask what your experience was of maintaining your schooling during this period of illness?

Ms Pattison: I had about three months off school. It was quite sporadic. Even then, once I was kind of recovered, occasionally I still needed to take quite a number of days absent—that kind of thing. It did not affect my schooling that much, but it made a huge impact. Coming back to school was very difficult because I did not know how to explain that I had been gone for three months, and it is also a very difficult thing to explain to peers at that young age. It is very difficult for them to understand. It is also very confronting for them. The school was aware of that. I needed to kind of figure out what to say without also overwhelming them. It was a very tricky space to navigate.

CHAIR: Was there any support from the school administration in navigating that?

Ms Pattison: To some degree. I think if this situation happened to me now, potentially there would be more support, but when I experienced this it was in 2010 so it was fairly new that somebody from this school would be hospitalised for three months. To be honest, I think they felt quite out of their depth. I do know that. They actually said that to my family. They said that they felt very out of their depth and they did not know what to do. They were given some advice by my healthcare professionals, but sometimes that advice was not actually taken.

CHAIR: Was it a state school or a non-state school?

Ms Pattison: It was a private school.

CHAIR: You talk in your submission about your experiences with the GP network. You talk about being prescribed medications and then not receiving much more support after that. Do you feel there is a need for ongoing case management or support for people who have a mental health diagnosis from a GP?

Ms Pattison: To some degree, but I also do not know if that is fair to a GP. It is not their scope of practice necessarily. They are not a specialist in that area; a psychiatrist is. Potentially we need to make psychiatrists more available. I think the big thing about going to your GP for a mental healthcare plan is that sometimes it is just typing in a postcode and seeing who comes up or seeing the best psychologist, seeing whoever they know. It does not necessarily mean that that person gets the care they need. Different mental health disorders need different kinds of therapies. They might accidentally send somebody to someone who does CBT and that person actually needs acceptance and commitment therapy. It would be lovely, in a very ideal world, if you had a middle person, so the GP said, 'I think this is wrong with this person and I think they could really benefit from'—whatever therapy it is—and the middle person then finds the therapist that does that work. It also takes the burden off patients having to call around and find a psychologist to get into.

Dr MacMAHON: Thank you for joining us today. Your submission talks about the challenges of navigating the system and affordability, and you mentioned giving people more choice in their treatment. What would have helped you to navigate that and give you a bit more agency?

Ms Pattison: I did not know about a lot of the other options that were available to me. You only become aware of those options when a health professional tells you that. I actually later became aware of them through a psychology degree. It is being aware of all the options available to the patient. Often we stick to a very, let's call it, CBT route, and sometimes patients do not get to know that they have other options available to them—even things like knowing that there are peer support services out there. I never found out about that until much later in life. I did not even know there were different types of therapy until I was 19. Having a health professional tell you all the options is really the only choice you have in that.

Dr MacMAHON: Were there any opportunities to connect with other young people who have had similar experiences to you and has that been helpful at all?

Ms Pattison: Yes, it has. I had one peer support worker when I was in hospital in an inpatient unit—I was in university at the time—and she actually told me some really helpful information about how to navigate university with health conditions. It was, I suppose you could call it, logical information. It was not necessarily that emotional support, but I needed somebody to tell me that because I actually did not know. Speaking to other people about your experiences is incredibly helpful, particularly young people, because it is a very unique experience to be mentally ill at a very young age.

Ms KING: Hi, Mia. I just want to start by saying I thought your submission was absolutely extraordinary. I have this long list of things I would love to ask you about arising from it, but time will probably not allow that. One of the things I did find really interesting, though, although I do not think you had a specific heading for it—it just came up over and over again. Correct me if I am wrong, but my interpretation was that you see a lot of need and potential for people who are experiencing mental illness to recover via kind of capacity building and skills and training. You talk about giving people the skills so that they do not return to EDs again or do not need to, and there were other examples I think through that. I wondered if you could talk a bit about that. Did you gain opportunities to build your skills in managing your own mental wellbeing? How could we do that better? If AM completely wrong in my interpretation, we can go somewhere else.

Ms Pattison: Different types of therapies give you different kinds of skills in managing a number of issues, but I eventually found personal recovery through one therapy that is a skills based therapy. It also depends on who you talk to. Psychiatrists could say something completely different. The tricky part about that is that that therapy is incredibly hard to access. I did know a couple of patients who when they were inpatients were referred to—it is called dialectical behaviour therapy. They were referred to a public DBT program and the wait was three months. They were released from crisis care with still a wait of three months. It is about making those skills based therapies more accessible. I am not entirely sure how, but somehow.

Ms KING: I also noted your comments about the trauma and lack of safety related to inpatient admissions in many cases. We have had other people come before us today and talk about the need for gender segregated inpatient facilities. Although you spoke about violence and sexual violence in those settings in your submission, I wondered if you had any reflections specifically on gender segregation in the inpatient setting.

Ms Pattison: I think there are pros and cons to all of it. There are definitely pros to having it gendered. When I was young and in an inpatient unit I was the youngest on my ward, being 14. I was with patients who were nearly 18, male patients, and it was intimidating. Some of them were there for a number of different reasons and it could have been more beneficial if I was potentially with more females but also people who were my age. The difference between 14 and 17 is huge. You are nearly about to drive and I was incredibly young. Those inpatient units for young people are very diverse. Sometimes that diversity is helpful and sometimes it is harmful.

In terms of safety, there was definitely quite a lot of violence in all the units that I experienced, yes, and unfortunately I think that was due to, as we said, it being a very sterile environment. It is an incredibly boring place. When people get bored they become frustrated, and unfortunately with a lack of de-escalation—sometimes the nurses were amazing and had great de-escalation tactics, but sometimes there was a lack of de-escalation or a patient felt they did not have what they needed and there was violence. It was very distressing to watch patients who were there to get help be restrained and secluded. It is a very sad experience to watch that happen to someone who has gone through very difficult trauma, yes.

CHAIR: That brings us to the end of the presentation. I would like to thank you for your submission and the evidence you have given today. It will certainly inform the committee's work going forward. This also brings us to the end of our formal hearings in this inquiry. We will now move on to the more challenging part of writing a report and making some recommendations that will hopefully lead to improving the lives of people affected by mental illness in Queensland.

On behalf of the committee I would like to thank Hansard, who have supported us through all of the various places we have been—and there have been many—and I would like to thank our committee secretariat, who have done an amazing job. I would also like to thank all of the amazing communities that have welcomed us as we have been working our way through this inquiry since January. I particularly want to thank all of the dedicated staff and volunteers who devote themselves to supporting people affected by mental illness, but mostly I want to particularly thank the people who have a lived experience of mental illness or alcohol and other drug issues or suicidality. Their input into this committee, which is where we started and where we have finished, has been invaluable and will certainly inform the thinking of this committee going forward. We hope we can create a report that is worthy of the input of those people and the faith they have put in this committee. With those few words, I would like to draw the committee to a close and formally close the hearing.

The committee adjourned at 12.46 pm.