MENTAL HEALTH SELECT COMMITTEE

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

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

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

TRANSCRIPT OF PROCEEDINGS

FRIDAY, 11 MARCH 2022

Brisbane

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The committee met at 9.02 am.

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

I would like to introduce the members of the committee. I am Joe Kelly, the member for Greenslopes and chair of the committee. With me are Mr Rob Molhoek, deputy chair and the member for Southport; Dr Christian Rowan, the member for Moggill; Ms Ali King, the member for Pumicestone; Mr Barry O'Rourke, the member for Rockhampton; and Ms Amanda Camm, the member for Whitsunday. Mrs Melissa McMahon, the member for Macalister, will be joining us at some point this morning. The purpose of today's proceedings is to assist the committee with its inquiry into the opportunities to improve mental health for all Queenslanders.

This is a proceeding of the Queensland parliament and is subject to the Legislative Assembly's standing rules and orders. Only the committee members and invited witnesses may participate in proceedings. Witnesses are not required to give evidence under oath or affirmation, but I remind witnesses that intentionally misleading the committee is a serious offence. These proceedings are being recorded and broadcast live on the parliament's website. Media may be present and are subject to the committee's media rules and the chair's directions at all times. You may be filmed or photographed during the proceedings. Images may also appear on the parliament's website or social media pages. Please turn your mobile phones off or switch them to silent.

I will remind all those who are watching the broadcast or reading the transcripts or who are here today that if the hearings raise any issues for you, please seek support. The contact details for support organisations are available on the committee's webpage.

BONETTI, Ms Megan, Senior Community Development Manager, Brisbane Housing Company

CANIGLIA, Ms Fiona, Executive Director, Q Shelter

KEEP, Ms Sonya, Chief Executive Officer, Common Ground Queensland

NEAVE, Mr Mark, Board Director, Common Ground Queensland

RUSSELL, Ms Kaitlyn, Community Development Manager, Brisbane Housing Company

CHAIR: I would now like to welcome these three organisations, because we particularly wanted to look at issues around housing and how it intersects with mental health, which we know is significant. I would ask each organisation to make a brief opening statement and then we will go to questions.

Mr Neave: On behalf of Common Ground, we would like to express our appreciation and gratitude for the opportunity to be involved in these proceedings. It is a wonderful opportunity to display and discuss the significant work that Common Ground does with a very vulnerable, highly complex and challenging group of people. As you are probably aware, one in five people suffers from some form of mental illness at some stage. The residents or tenants at Common Ground are those who have the most complex problems, be it based on sexual abuse, mental health or domestic violence issues. We offer a very strong opportunity for people at West End, with 146 units to have and call home. Sixty-seven per cent of those tenants have been diagnosed with a mental health illness.

One of the key elements around Common Ground is to break down the barriers and have inclusion. I will not go through the details, which are in the submission, except to say that we are constantly building partnerships with not just academic worlds but also where we look at best practice and contemporary research to ensure we are offering the best service we can to those most vulnerable people who are homeless or who are at risk of being homeless. One of the things around that too, apart from inclusion, is that we look at empowerment and the right to choose as part of that principle. One of the key elements of our philosophy of care is the recognition of hope. That is a key element that we often hear when people have been staying at Common Ground for a short period of time or a long time: they feel as though they are being heard, they feel as though their quality of life is back on track and they just believe they have a life again.

Ms Caniglia: Thank you for the opportunity to appear today. Queensland Shelter is the peak body for housing and homelessness services in Queensland. We know that the organisations that are our members and stakeholders work with a disproportionately high number of people with significant mental health challenges. The integration of mental health responses with housing and homelessness responses will measurably reduce homelessness in Queensland. There is a lot of good work happening, and we have just heard one case study on point from Common Ground. I think there is a lot more to discuss and agree on how we can go forward to fully integrate support and housing in a way that addresses people's mental health concerns and also reduces their homelessness in an enduring way.

Ms Russell: I would like to thank the Mental Health Select Committee for inviting us here today. This is an area that BHC feels very passionately about and it is a significant issue for many of our residents. We believe that secure and stable housing is an important piece of the puzzle to help improve mental health outcomes for Queenslanders. Safe and secure housing often provides the stability needed to focus on personal wellness and other positive life outcomes such as connection to community and employment. Whilst I can sit here and talk about the positive outcomes we have seen, unfortunately all too often we witness how someone's housing can be jeopardised by poor mental health outcomes. Without the right support and care, mental health can become absolutely debilitating and impact all areas of a person's life, including relationships, employment and even leading to homelessness. We would quickly like to share one more story from one of our residents which highlights the importance of access to early intervention, care and support to achieve positive mental health outcomes.

Sue found herself isolated and without support when her undiagnosed bipolar disorder left her manic and unemployable. After a series of overwhelming life events and losses, in 2010 Sue lost her job and fell off the grid in 2011. She began abusing drugs and entered a year-long psychosis. During this time she was evicted from her home, was blacklisted on TICA, was alienated from her family and friends and began a volatile relationship. It was another year later, after repeated hospital admissions, that Sue was finally diagnosed with bipolar type 1 and PTSD. After struggling for years alone dealing with what she thought was chronic depression, Sue was able to get support from her family to begin her recovery journey. For 3½ years Sue was in and out of hospital as she struggled to find the right mix of medication to support her mental health and come to terms with her diagnosis. Sue reflected, 'Compassion can come from unexpected places.' Having support from key members of her family and being assigned a community mental health nurse were the turning points and ultimately what led Sue to secure long-term affordable housing with BHC. In early 2017 Sue moved into her new home with BHC and began the process of building a new life where was she was supported by the mental healthcare system, aware of her mental illness and with growing support from friends and family. Sue said, 'What people don't realise about mental health is the importance of environment. A stable home is so important.' I am pleased to say that Sue is still a resident with BHC today with a secure home where she can continue to improve her mental health outcomes.

Despite having a happy ending, I ask you: could we change this story? Can we strengthen our mental health system and our communities and equip them with knowledge and programs to support people before they reach crisis point? Can we help stop the cycle of homelessness caused by poor mental health by supporting people before they lose their homes and become more isolated, more vulnerable and in need of even more emergency support? Whilst we value immensely the existing mental healthcare system, which is already striving to support Queenslanders, we know that more can be done. We believe there are pathways forward.

CHAIR: In relation to the question you posed around what more can be done, it strikes me that that relates to what we refer to as the 'missing middle' that seems to sit outside the remit of community housing providers. Is that fair to say? I would have thought that many of the people your organisations engage with are on the other side of the equation with diagnosis in terms of hospitalisation or experience with mental health services. Is that fair to say?

Ms Bonetti: 'On the other side' as in they have already been diagnosed?

CHAIR: Yes, they have been diagnosed, they have been to hospital and they have been discharged and rehabilitated.

Mr Neave: Absolutely.

Ms Bonetti: Yes and no, I think. In my short experience in the housing sector—I have been with BHC almost six months—I have done two examination authorities. I am a social worker. I have never done examination authorities before in that the person had to be removed from their home because their mental health had declined so much and they had not had a diagnosis of any kind, and in that they were able to go to hospital and seek medical help.

CHAIR: In those instances people were already in a BHC facility and their mental health declined, and that was picked up by yourself or your organisation. I guess that is what I am driving at. We have heard suggestions from other submitters that if we are going to have case management or social workers we should be considering locating those in organisations that do things like community housing. Do you all have social workers and case management?

Ms Keep: At Common Ground we have basically onsite support providers who are case managers, social workers. We point our service at people who have experienced chronic homelessness. We know that 70 per cent of those people are experiencing mental vulnerability. Often people are not cured of these things, but in this moment they are able to be supported and able to live within a small, caring community that supports people to build their resilience. The thing that we see over and over again is that when you get in and do that proactive early engagement you stop people from spiralling, so people do not end up at the chronic end. The behaviours that people experience that cause them to lose their housing—we are able to stop that cycle so people are able to stay in their home. They are supported to be as well as they can be and to live with their vulnerabilities.

Mr Neave: That support that has been offered by our partnership model is based on the interpretation of need. It is high intensity or low intensity based on need. In relation to what you are alluding to with the recidivism rate, there is probably evidence around that, where it is being reduced and taking the pressure off some of our normal mainstream mental health services.

Ms Keep: That is what our independent evaluations displayed right back at the beginning—that is, the reduction in those mental health presentations to EDs because people had that onsite support service. We fully believe in, and have seen the evidence of, the value that is provided to people when they have that support that is integrated into their housing. I think that is what differentiates what we do—that we have that intentional linkage between the housing and the support services. If you are able to replicate that and get it to scale, you will see the savings in those other systems. When you do it on a small scale, we obviously are able to have a big influence for a number of people, but if you replicate that you will get changes and savings in other systems.

CHAIR: Sonya, in your organisation, is the housing solution long term, or is the case management about trying to assist people to stabilise over a period of time and then look for other options? What is the approach at Common Ground?

Ms Keep: It is a real personalised approach. Our housing is permanent. Support is there and available for everyone for as long as they need it, but it is voluntary engagement with that service support as well. On average, people are with us about two years before they move out onto other housing options. We have other people who have been with us for the 10 years that we have been open and we expect they will be there their full lifetime because we know that in any other environment they are going to move back into homelessness.

CHAIR: In terms of the case management, is it purely case management, or in some instances do you have nurses, psychologists or social workers who can do other types of therapeutic interventions as well as the general case management?

Ms Keep: We definitely have a nurse on site. We also have a health centre that is within our facility. Helping people manage their medication and their mental health really makes a big difference to their wellbeing and their ability to be a good tenant, neighbour and all those things. Nursing has been a critical part of the model. On top of that, we have social workers with specialisation around alcohol and drug, mental health and those types of things. You get that real multidisciplinary support.

CHAIR: Fiona, we went through this deinstitutionalisation phase, but through our electorate offices and our work in the community, through my work as a nurse in hospitals and through talking to police and teachers, you come across people who clearly need some degree of assistance and support but there is nothing available. They have been given a house but nothing else. From a sector-wide perspective, is that a common situation?

Ms Caniglia: I would have to say that it is common. Not everyone who needs support gets support. I think Common Ground, BHC and many of the community housing providers that we work with work very hard to build partnerships that are robust and that sustain people, but there is not a support guarantee for everybody. Deinstitutionalisation was one major wave of change, where many people who were highly vulnerable found themselves technically living free of institutions but having to rely entirely on a very substandard private rental market, which was mostly boarding houses and hostels. That was when I was emerging in the sector and there were so many boarding houses and hostels—there were hundreds of them in Brisbane housing people who had left institutions. I think all of us at that time hoped for better lives, but it was not necessarily a better life from a housing standpoint or from the standpoint of support.

I think we have come a long way. CHPs are playing their part. There are systemic issues to talk about here, and then there are the issues that centre around individual needs for support. The systemic issues are that we need to get the housing equation right in terms of supply and demand. It is really critical that we work at a systems level. I commend the government for the Queensland Housing Investment Growth Initiative. Nearly $3 billion worth of investment in the future of social and affordable housing in Queensland is absolutely wonderful, but we also need to be working on the broader housing system in terms of setting targets for housing supply and reforming the planning system so that we have opportunities to see social and affordable housing built in communities throughout Queensland.

When that supply and demand equation is right, really vulnerable people find themselves less likely to be competing and not succeeding in the quest for an appropriate place to live. That is the broader healthy context in which all people can find, get and keep their housing. We also need to see the investment growth initiative by the state succeed and expand so that there are more community housing providers delivering social and affordable housing in robust partnerships with support providers.

The last thing I would say is that Q Shelter is calling for a tenancy sustainment support program in Queensland. Other jurisdictions that meaningfully reduce homelessness have support programs—much like Sonya describes but more widely available to community housing providers and in fact public housing and people living in private housing who are hanging on but still need that support. We need a tenancy sustainment framework in Queensland and we need that to be underpinned by the supply side, the systemic side and the right level of investment in support which is geared to a housing mindset that no matter what other wellbeing domain we work on—and all of them should be in scope—housing is at the centre of that and we are working with a housing mindset.

We think mental health specialist services can play a really significant role in that as well so there is an existing support infrastructure, and our submission talked to that. It is really important that upstream mental health workers working with their clients to support them have a really great level of housing literacy, they understand how to work in the housing system and they understand how to put people's housing in the centre of any support plan they are working on. We do think there is a bit of a broader workforce development piece to work across state agencies in terms of health and housing to achieve more integration of inputs and more upstream responses so, as others have said so well, we are not dealing with downstream crises and all the human impact that brings.

CHAIR: I was going to ask you some questions about your tenancy sustainment framework. I really picked up on that housing health check that you talked about because I can tell you that after 30-something years involved in nursing I do not think I have ever asked whether we should put rails in a bathroom when we were discharging someone. I would say that every MP has the same experience—where we have people approach us who are sliding towards homelessness. They come in for a range of reasons and then seek our assistance, or we become aware of the need for assistance. Is there more we can do at that end of the spectrum around trying to prevent people from finding themselves homeless or needing social housing?

Ms Caniglia: It is critically important that we do not only live in a context in which we think about social housing as the whole solution. I think that has been a maturation of our thinking at Q Shelter. It is about getting that whole-of-housing-system equation right and working at every level—so more granny flats and more inclusionary options where big master planned sites have the right kinds of housing mix included. Housing diversity is really important.

In terms of the support side, we are working through a state government initiative on a service integration initiative which involves active facilitation of a diversity of services to the table to bring forward individuals and households and work the problems until we have solutions in terms of housing and support. What has really shocked me is that over half of the referrals come from outside of the housing and homelessness sector. They come from mental health; they come from drug and alcohol services; they come from neighbourhood centres; they come from family support services. People are presenting in these kinds of crises everywhere. Emergency departments of hospitals are another really important case in point.

People are presenting all over the place. They go where their relationships are or where their most immediate needs make them present. We have a vision that every single person at that juncture, in that point of relationship with people, could be better equipped through organisations like Q Shelter to ask the right questions and then appropriately plan with the person about who they need to be supported by and how to prevent a worsening of those circumstances. We think there is work we can do upstream with the broadest number of human services—every single touchpoint. I do not want to be sending everyone to a housing service centre. I do not want everybody to be pushed through the eye of a needle into specialist homelessness services. It is no answer for anyone. By the time you get there, things are so bad and people often do not have the will to change it. They feel so demoralised and so traumatised, their brains are not even working to solve the problem. We would love to work with the state government upstream. That is what we think is really critical.

CHAIR: That is interesting. I am sure every MP at the table has the same experience, but there are often times when we become aware of an issue and it is usually people in the community complaining about somebody else. By the time we get involved, there are often multiple agencies aware but they are not necessarily talking to one another and they are just trying to solve their bit of the problem and not looking at what the person in the centre needs. It would seem to me that there probably needs to be more of that occurring proactively rather than waiting for the crisis point and then reacting.

Ms Caniglia: I think the state government is to be commended for funding nine regions in Queensland with regional facilitators trying to pull housing, homelessness and other services together to really integrate service delivery at the front line. It is excellent, but there is a lot more work to do. We have all sorts of things to overcome. Some of it is about how the system is designed and how it has unfolded. Trying to make a system work even if it is not exactly fit for purpose is a challenge—trying to help organisations and individuals feel no fear about partnering and sharing information, trusting each other to do different things but complementary things. I think there are so many layers to this, but having regional facilitators is one step. We are working with the state government to bring more of those facilitators into regions.

Most human services systems are very complex. I know that navigating that around aged care for a parent took me to the edge of my abilities. I think it is very complex. When you talk about people in a state of trauma who are very vulnerable, we have to do the hard work and make the system work for them. We cannot expect them to have a detailed, complex plan for themselves and navigate all of that with total success. We need to do that shoulder to shoulder with respect for recovery and self-determination, but the sector and the system has to really rise up and pull together and not let people fall through the gaps.

CHAIR: Then we have a shock like we have had in the last two weeks where we get a couple of thousand people homeless overnight and that puts a lot more pressure out there.

Mr MOLHOEK: I thank you all for coming today. Fiona, about six months ago my wife rang me and said that there was a lady on the streets down at St George Bank claiming to be pregnant with six weeks to go. She was homeless and begging for money. My wife said to me, ‘You’re a member of parliament. You should be able to fix this.’ So I rang Micah Projects at the time and someone got on their computer and then asked me, ‘Does she look like this?’ She did, so Micah said, ‘We’ll send one of our outreach workers to talk with her again.’ They had housed her three times. She had been in and out of a couple of relationships and the pregnancy was just a ruse to try to get more money. She was not pregnant at all. Ironically, I actually walked down the street about three nights ago and she was in a new location with a different sign. How do we house the people who do not want to be housed? The issue with her is that she has been in and out and she keeps saying, ‘I don’t want to be here. I don’t want to give up the 30 per cent’—or whatever it is—‘of my dole cheque because that’s money I could be using to buy drugs.’ How do we reach those people and get those people off the streets?

Ms Caniglia: It is a really important question. In systems where there has been a significant, measurable reduction in rough sleeping, there has also been a residual population where it is much harder to get the same result. It usually is around the number of overlaid factors. It is very difficult with significant substance use and addiction issues, for example. If that is layered over underpinning mental health problems and other kinds of early life experiences that make it harder for people to form attachments, make decisions and sustain those decisions—which goes to some of what does happen to people if their development is not optimal—that is really hard.

As a leader of a peak body, we cannot give up trying though. I think it is about constantly-evolving models that work really intensively with people in a situation like that. We talk about rapid rehousing. It is really important that if it does fall apart—first of all, you have to prevent it falling apart through intensive support. If something goes so badly wrong that people abandon or re-emerge on the streets, it is about re-engagement really quickly to rapidly rehouse people if you can. That seems to be better for people than if they spend longer and longer institutionalising themselves on the streets. It is also about the diversity of housing products. We have let go of institutions—we should have done that; that was the right thing to do—but sometimes we do not have environments that have the right levels of kind structures that give people the boundaries and the support they need to just keep going every single day.

I do think we have overreached into the idea of the least restrictive alternatives. Some people just need that additional support in the environments in which they live. I do not think we at the moment have the right diversity of housing models to pick up on those people. I also want to humbly say that it is a really big challenge for that residual population, especially if addiction is in the mix. I would love to take the opportunity to say that we have had recent discussions with the director-general of the department of communities and housing about working upstream with people—identifying at-risk people, pregnant people and children born into families that are really at risk. Some jurisdictions in the world have incredibly intensive early life programs of support going into the home—being there in the morning, being there after school—really intensively supporting at-risk families to reduce the exposure of children to adverse events. The science shows that children who have experienced adverse events in the first 1,000 days of life effectively acquire a cognitive disability. Every dollar you spend at 15, 20 or 25 has so much less impact than working at the front end.

I would love to see Queensland, at least in a test site, work on a very early life intensive program that takes the best evidence the world has and really brings into the mix the idea of trying to prevent that trajectory for at least one generation of children. I do not think we will see a change to the population of people that you just described until we are working more effectively in child protection in terms of those models but also proactively finding vulnerable families and preventing exposure to adverse events, because that does terrible things to the human brain in terms of cognitive development.

CHAIR: Where have those programs been implemented? You said there were several countries that have done this.

Ms Caniglia: We have some good examples in Australia. There is the Abecedarian model in the Northern Territory. There are really an intensive models of child support in the UK. Scotland has been progressive. I would really like to take the opportunity to provide more information, to bring forward some of those models. As recently as the last few weeks we have discussed that with the director-general. It is a positive discussion and I think we need to take that further.

Ms CAMM: I think Logan Together and Griffith University have done amazing work in that space as well. Both Q Shelter and Brisbane Housing Company outlined in submissions the impacts of the NDIS and how the change in service delivery is impacting on your clients. More broadly and holistically, it is a theme we are hearing when we travel. Can you expand upon that? Where do you think the NDIS has either potentially delivered or created greater gaps? There may be unintended consequences, but certainly there are key themes we are already seeing. Can you expand upon that in your experience?

Ms Russell: Absolutely. In our experience, definitely we see examples of great success where our residents have been able to link in with NDIS and have been able to get greater support. That is absolutely fantastic and that is what we want to see. However, we also know that there is a percentage of people who find it a greater barrier now to apply for and get access to NDIS. It is a very rigorous process and it can often be extremely overwhelming for someone to even look at and begin that process, especially if they do not have a support worker or someone beside them who could assist them with that. If they are independent and have not linked in with that support already, after looking at that documentation and that assessment process and also hearing from the community that there are people who are being knocked back and being told no, they think, ‘Why bother?’ It is really disheartening for them and an overwhelming situation that they say, ‘Well, I won’t bother going down that path because I probably won’t get approved anyway.’ We see that as a severe issue.

There is also definitely a demographic of people who previously had access to support in their community; however, those places are now tied up in NDIS funding. If they are not linked in with NDIS already, they lose access to supports they were already accessing. Unfortunately, that is something we have heard across our entire portfolio. Whilst, again, we do have those wonderful examples that there are spots available for people who have the funding there, someone who was able to connect in with those resources on a really local level is now being told, ‘No, sorry, you don’t have the funding; we can’t support you anymore.’

Ms Caniglia: Very consistent with that, two programs that really made a huge difference to people were the Personal Helpers and Mentors program and the Partners in Recovery program. Both were roped into the NDIS, but not everyone getting those services gets on to the NDIS. That is two direct examples of people losing services, effectively. Those services were playing their part in helping people sustain their tenancies.

Ms CAMM: Sorry, what programs were they?

Ms Caniglia: Personal Helpers and Mentors and Partners in Recovery, both federally funded. Both are really useful types of models. They have had a substantial impact on the amount of support available to support people in organisations like the ones represented here.

Mr O’ROURKE: Thank you, on behalf of the people of Queensland, for the wonderful work that you do in the housing and homelessness sector. I worked in housing for many years and know how complex it is out there. The Common Ground model is amazing and the outcomes you achieve are just wonderful. It is a great model. I would love to see a whole lot more of that around the state, I can assure you. I know that PHaMs and Partners in Recovery provided an absolutely wonderful service to some of our very vulnerable. Is there anything out there now for those who are not on the NDIS or has it really just fallen back onto organisations to try and pick up the pieces for these people?

Ms Keep: We are not funded for (inaudible). We are lucky because we have got the funding allocated to do that support. The other thing I would say is that it does not always have to be in a big building like Common Ground. You can do it in a scattered site model or in medium density. It is about that intentional linkage between the housing and the support—not the facilities specifically.

Ms Caniglia: I think specifically around mental health people do get a lot of support from a variety of not-for-profit organisations running mental health type programs. There are a variety of other kinds of support programs as well. There is general community support funded somewhat through the department of communities which is a useful program. It is partly the opportunity and the problem that there is a patchwork quilt of funding arrangements. I am not suggesting any radical change to that, but one of the points we made in our submission is to say, ‘Well, what are the points at which people do make significant contact? Where are they getting their support? How do we make sure those support providers are really literate about how to sustain tenancies and really lift that capability?’ Even if you leveraged all of that—and we sit at these care coordination tables with multiple services region by region, and sometimes support agencies have waiting lists. Common Ground and BHC will say, ‘We don’t have another empty home for someone to live in.’

The support sector cannot stretch the elastic band too much, because you start to reduce quality and start to take significant risks. You cannot carry super-high caseloads. It is not just an ever-expanding set of capacities. We need the recognition that there is support out there. It needs to be well integrated and coordinated; there is no doubt about that. The models need to be right to put tenancy sustainment quite in the middle of what those workers are doing; however, there is a gap in support. We do not make ambit claims. It is really important that Queensland thinks forward to a tenancy sustainment support program that really does lift the capacity of the sector to offer that support guarantee where households are really vulnerable. Most people really do not want their housing to fall apart but on their own they are not able to do that. With that sort of support, I think we would see measurable results.

Mr O’ROURKE: I have a question around the National Rental Affordability Scheme and the expiry of those leases in the next year or two. There will be quite a few properties. For the housing sector, are you aware of any planning around transition of those tenants into more affordable housing as those leases expire?

Ms Russell: BHC is in a unique position. We were actually involved in being able to manage some NRAS properties from private owners on their behalf. That was a really wonderful experience. We absolutely believe that NRAS was a fantastic program for Queenslanders and definitely looked at addressing that gap, that in between, for people who were not yet in that emergency crisis. They were able to register on the department of housing waitlist. They were able to get support for housing in that sense. They were in a situation where they were falling into financial crisis themselves. They are putting themselves in a position where paying a substantial level of rent every week is not sustainable. It does not allow for people to explore and support those other really important areas of their lives that may need attention and focus, such as mental health.

From BHC's experience, it was of particular concern that that program is ending and we are seeing that come offline. Because we are also a community housing provider, we are working very intentionally with all of our residents to make sure there are options for them. Unfortunately, we are seeing a rental crisis. We are seeing the prices of private market rental absolutely skyrocket and further jeopardise people's housing situation. Where possible, absolutely we are trying to work with residents who are currently housed to find suitable options for them, but we also know that there will still be a gap. There will still be people who cannot afford their market rent—it will be a real struggle for them to move back into the private market sector—however, they not going to qualify with department of housing to be considered for community or social housing. What happens to those people? What more can we do to support them?

Mr MOLHOEK: We need to go back to the old blue collar housing model of the 1950s and 1960s, don't we?

Ms Russell: I will be frank: there is a really specific level of detail in terms of how BHC operates and our partnership with the department of housing. The bulk of our residents come from the department of housing waitlist. They have to be on that waitlist to qualify for housing with us. However, we have seen that number rise substantially over the years. What we see now is that the residents who are able to apply with us are the absolute extreme of people needing that support and people who are at the height of vulnerability and crisis. There is that mid-bracket that is still being missed. We are not seeing those people on the list and being able to offer housing to them. What happens? Do we wait until they become homeless, living on the street or couch surfing, and their mental health deteriorates and the acute admissions in hospitals rise again? It is a significant issue.

Dr ROWAN: Thank you to all three organisations for appearing today, particularly to Sonya Keep and Mark Neave. I have been to Common Ground a number of times. As a patron and honorary ambassador for Upbeat Arts, which provides a range of arts, choir and cultural programs, it is great to see the work you do over there. Joan Pease, the member for Lytton, is also a patron. I know that all three organisations here are doing very important work in relation to homelessness.

I want to ask about the submission from the Brisbane Housing Company. It was said earlier that improved communication across service providers better supports not only recovery but also early intervention and care. Do you have any specific recommendations about strategies—for example, IT systems and the use of videoconferencing and case conferencing? There are a lot of things to support clinicians, but often the clinicians liaise with nonclinicians—that is, the people who might be providing a range of services. What things can be done to enhance that communication across the ecosystem, let us say, of different service providers providing different things, between clinicians and nonclinicians? Do you have any recommendations for what the state government or the federal government could do to enhance that communication and coordination?

Ms Bonetti: You just mentioned a key point at the end: the state and the federal governments. What I have seen is the breakdown of communication between Services Australia and Centrelink and RentConnect and the supports around rental arrears and things like that through Centrelink versus the acute-care supports of the state government and local hospitals. As an example, we had a gentleman whose mental health had significantly declined. He was one of those examination authorities that we had to remove from his premises and he went to hospital to become well. I had to very tenaciously almost force the systems to talk.

From an acute-care perspective, he had been diagnosed with schizophrenia maybe six months to a year earlier but that information had not made it to Services Australia and he was re-streamed and put into jobactive. He was pulled out of disability support service, DES, which he was in and he was re-streamed because he had an appointment with Centrelink and they basically said, 'You seem fine,' and they put him in the jobactive stream. His reporting requirements were increased and then he became unwell—he was very paranoid about the government and reporting and he had thoughts of grandeur—and then his rent got cut off. It took him having to go to hospital for that to all be sorted. Again, with that early intervention engagement we would have avoided that whole situation. If it was picked up by a support service early on that his mental health was declining then potentially he would not have been admitted and he would not have gone into such significant arrears. I guess the solution in that scenario was having a really strong advocate for the individual in the housing space. That comes back to that sustaining tenancies model.

I can give another personal example. I know you have QPASST coming in later today. I had a meeting with QPASST and they had two young women from a torture and trauma background—a refugee and an asylum seeker background. They were 18- or 19-year-olds who had been living in their cars for about a year and were really struggling to find stable housing. The support people found the barriers around these young women: that they have experienced extensive trauma and are facing domestic and family violence, that they are young and are navigating systems, and that English is not their first language. The support providers themselves were like, 'We don't even understand the complexities of the housing model.' It is like what Fiona was saying—that we do not understand it so how can they understand it? That whole meeting was to provide education around the housing system because the support people did not quite understand how to navigate and advocate in that system as well. I think that sustaining tenancy concept as a broad, overarching, funded kind of statewide support that all services can tap into is a really great idea.

Ms Caniglia: We talk about a tenancy sustainment framework. It is not just about more funding; it is about the quality of how all of the different parts of the system fit together and every vantage point in the system playing their part—housing and support.

One of the things we have said in that tenancy sustainment framework is about information technology underpinning a better approach to integration. I think it needs careful discussion, and there is some discussion underway within the department of communities and housing about data sharing across agencies that are directly involved with assisting a person. It is not like taking an ad out in a newspaper; it is a very focused, carefully structured set of arrangements in which a client is supported to consider whether they give consent to the cluster of organisations that are working with them communicating with each other effectively. They already do that very often but without information technology backing that up. We have been advocates of using integrated case management systems supported by technology to enable people to do the work of stitching together a response to those circumstances in a way that prevents people from falling through the cracks. We would really like to see that come to Queensland.

CHAIR: I could not agree more around integrated case management systems, but as we have seen from My Health Record it is not exactly welcomed by the community, unfortunately.

Your example reminded me of this problem I have encountered. I know from my perspective in our office if we are assisting someone and a mix of services are involved, we have great access to the state services but if something involves Centrelink we have to refer on to the federal member because Centrelink simply will not talk to us. I have no doubt it is the same going the other way, but there seems to be that real challenge between state and federal departments—and probably even local government departments, although they seem to be a bit more amenable—talking to one another about the same person in terms of coordinating services.

Ms Caniglia: Agreed. I think some frontline consortia of organisations sitting at these care coordination tables are working with Centrelink more effectively. That is really good—to find a contact point and make that relationship work in terms of the unfolding plan, hopefully with a good outcome. I do think we lack the protocols and the systems between levels of government but also between agencies funded by the same government that are not necessarily fully able to communicate with each other. I really take your point that change is hard when it comes to information sharing, but I have to envision a future where we can absolutely protect people's information but enable the right people to talk to each other with the person to get the best outcome possible. That is really worth keeping our minds open to.

CHAIR: We are happy to share every bit of our personal data with Meta, but if you have to tell a nurse or a doctor about your health problems that might actually keep you alive it is, 'No. I'm not doing that.'

Dr ROWAN: To Q Shelter or Common Ground, what are you seeing with respect to alcohol and other drug conditions amongst clients? I wanted to get a sense of changing issues within different demographics and what that means for homelessness and the level of service provision that is available. Do you have any recommendations with respect to either detoxification beds or service provision as it relates to what is provided via the Queensland government? Common Ground is on the south side of Brisbane. On the north side of Brisbane there is a hospital alcohol and drug service (HADS) at the Royal Brisbane, and feedback that I have always heard is that there should be a similar thing on the south side of Brisbane. Do you have any thoughts or recommendations about what is needed to assist people in detoxification and rehabilitation and what you are seeing amongst clients?

Ms Keep: It is a very complex issue that often has its origins in the trauma that people have experienced as children. Again, that relates to how we work intensively with people to try to unpack that for them and lead them on to a treatment plan where those services are available at the time when they want to engage with them. Having people who have those skills to work with people with significant trauma at the beginning is a big issue. Even in our context—where we probably have more resources than any other housing provider—we still struggle with that and having that specialist skill. Then when you get a person to that point where they are willing to engage, there is not a bed available.

The other thing we often see is people going to mental health and being turned away because they are classed as being affected by alcohol or drugs as opposed to having a mental health issue. They just get turned around and sent straight back to us—when we know that is such a difficult thing to sort out. Is it alcohol or drugs or a mental health issue? It is the cart before the horse. They need to be treated as someone who has a vulnerability and supported to be well again rather than discarded as someone who is just drug affected. They are the two major things we see that we could improve. With resources pointed in the right area, you could get a very different outcome. I think that is what that trauma research often says.

Dr ROWAN: I want to go to that link between adverse childhood experiences or trauma and homelessness. Your three agencies are seeing people over a long period of time. I do not want to put a definite percentage on it, but is there a rough indication of the link between adverse childhood experiences and homelessness?

Ms Keep: I think it would be in the high 80 per cent. It is a major driver of the issues that we see. People have nobody who loves them, who has ever loved them.

Ms Bonetti: There is that cycle of trauma. The member for Southport mentioned that woman he met on the streets. Potentially she would have had barriers with drug addiction, alcohol or whatever it might be—I do not know her story and I do not want to presume. It is just how Fiona has said—that those early interventions at a young age are so important to avoid that cycle of intergenerational trauma. You reach that point where it is hard to work with people who have such complex needs and complex trauma and mental health and addictions.

Ms Russell: I wanted to say something about the drug and alcohol and rehabilitation services as well. There is a really serious issue that I have seen personally over the years working with BHC, but unfortunately we did not include it in our submission because there is just so much to cover. If a resident who is on a support payment—and that is how they are paying their rent with us—is suffering from drug and alcohol abuse and they need to go into rehabilitation, that comes at a cost. They can take the money for that service from their pension payment and use that to go and get rehabilitation services; however, they cannot also continue to pay their rent with us.

There are a couple of options. If there is no funding to be able to support them to sustain their housing whilst they are attending these services and getting the much needed help, the option is homelessness or attending drug and rehabilitation services. What kind of an option is that for someone? The other case is that they hold onto their tenancy and do not end their tenancy with us, but when they come out of drug and rehabilitation they have massive amounts of rent arrears and are in financial distress.

Ms Bonetti: Which perpetuates the cycle.

Ms Russell: Absolutely. They are in a highly stressful situation. They come out of that safe and secure environment where they are getting treatment and help, and they are put immediately back into an extremely high stress situation. How is that helping to break the cycle? It is just perpetuating it.

Ms Keep: What we do at Common Ground in that circumstance, because we have the partnership between ourselves and the support provider, is reduce their rent to the minimum rent and the support provider uses their funding to pay that rent for them so the person is able to do both—keep their home and access services.

CHAIR: Does any federal or state government department keep any record of adverse childhood events?

Ms Caniglia: It is a really important question. There would be a lot of data that the state government would hold about people's histories, but it would be distributed across different agencies. We have also been in recent discussions about data-matching studies that try to bring together the data available on people's early childhood through to other stages of life. We think those kinds of data-matching studies are very valuable and we are certainly advocating for those. In terms of the history—how much we know and how many people with those histories have come through—it is not necessarily an easy number to pull up but anecdotally we know. Again, a research agenda that follows a generation of children to see that trajectory is really important. Once you hit the child protection system, the vulnerability to later-life homelessness is significant. It is one pipeline we could try to stop.

CHAIR: Is the evidence settled or leaning strongly towards adverse childhood events having negative impacts? Is there a settled definition of 'adverse childhood events' from an evidentiary perspective?

Ms Caniglia: I will take it on notice to also forward the research that we draw upon in this space. If children have been exposed to a significant number of adverse events by the age of three, their brains are scanning smaller than the brains of children who have had all of their needs met. I do not want to sound like someone who is judging those parents. I think this is an intergenerational set of challenges about trauma raising trauma, and we have to address that. There is great science. It is tragic science, but it is very clear.

Ms KING: Kaitlyn, thank you for raising that issue about people going into treatment. An extended family member of mine experienced exactly that. In order to attend inpatient drug and mental health treatment, their family was impoverished because they lost her share of the pension. The impacts of that were ongoing and ultimately tragic. I am really glad that you put that on the record.

I want to ask for some commentary about the impact of the changing private property market. My community, which is outer metro, has always been end of the line for affordable housing. It was as far as you could probably commute to get to work in Brisbane and rent was cheap. Over the past few years that has changed dramatically. Rent is not cheap anymore; it is absolutely unaffordable for many people. On top of that, we are seeing around 140 NRAS households who have had this guillotine hanging over them for years now—knowing that they are going to lose their housing and knowing that they cannot afford an equivalent replacement.

What I experience in my role is that these factors—these hostile systems and financial pressures from the housing market—are causing mental ill health. People who may have had vulnerability previously are now presenting to my office in clear mental health crisis. You have spoken about the close relationship between housing and mental health as an each-way thing, but I am seeing housing pressures cause mental illness. Is that your experience?

Ms Caniglia: It is really true that it goes both ways. We all could recount case studies of people who have been living their lives, and an adverse event like an accident—and this is a real story—caused a pregnant young couple to need emergency accommodation. When some of the rules around what they could get access to prevented them from accessing that before their baby was born, the conversation then turned to perhaps Child Safety involvement. You can imagine going from life going really well to life being this spiral of not having any control, even over the future of your child. It is devastating. We are in contact with a huge group of older women in housing stress. That has been one of the saddest things to see—people who have been strong and resilient their whole lives living at this stage of their lives with the deepest kind of anxiety. I think people do acquire depression and anxiety from not knowing where their next house is going to be.

To the points about the private rental market, this is the worst time I can remember—and it is going to get worse with houses coming out of the market because of the floods. It will cause more demand pressure on a rental system that cannot cope. It is a really big challenge. We would need to reach deeply into the community and really cast the net for any properties that can come into the rental market as a short-term solution, to see even if there is any scope to bring short-term rentals back to the long-term market or to find empty properties that people might be willing to bring forward. We are not even saying to bring them to community housing providers. Bring them to any real estate agent anywhere in Queensland, because just about anywhere will be helpful to a system under so much pressure. It is about that reach into the community with an appeal.

The prospect of continuing NRAS has been a pretty flat ‘no’ from the federal government. Of course, nobody could control the floods or the pandemic. Given these external factors—it is a bit like a battle, really—is there any chance of reconsidering the future of NRAS at this moment in Australia’s and Queensland’s history? Is that a possibility? Time, place, opportunity: is it another chance for us to ask the question about NRAS? If those people tip out of NRAS in the next couple of years, in the worst market we have ever known, I think we will see a mainstreaming of homelessness that I probably never imagined when I emerged from university and wanted to try to make a difference.

Ms KING: Of those people who have contacted me in my electorate office, overwhelmingly they are women in their late 50s through to their late 60s. I find that profoundly frightening.

Ms Caniglia: It is a good case study of how NRAS really did help people not tip into needing social housing. Many older women have done well through NRAS but we are getting the calls, too, about how anxious they are about the future. It is a case in point about why affordable housing is important. Social housing is very important, but affordable housing products that are discount to market rent help a lot of people come off the register and prevent a lot of people going on the register. It is not one or the other. We cannot treat these things as binary or one as being better than the other. A healthy housing system will have a good measure of both.

Ms Keep: At the end of the day, they need a subsidy from government. In terms of all of the methods to try to work out how the for-profit sector will fund this or contribute to it, the fairies are not coming; they have no fairy dust. It is math. We need a subsidy to make up for the cost. People who live in poverty cannot pay enough rent to make that housing transaction viable.

CHAIR: We are obviously about to go through a period where there is significantly increased demand, not just across Queensland but in New South Wales as well, because of the floods that we have experienced. Some new social housing complexes are being built in my electorate, but they are 18 months of work at least, if it does not rain. Is there a case for some sort of faster, short- to medium-term housing solutions to try to take some pressure off the system but not have those turn into institutions? I am talking Wellcamp but closer to Brisbane.

Ms Bonetti: It is probably what Fiona said around digging deep—everyone letting go of their properties. It is a miraculous thing in a way.

Ms Caniglia: I think everything should be on the table, because this is a crisis of extraordinary proportions—any infrastructure the state government has. I have been around the state on various trips to talk to regional services. I have been in Townsville for the past couple of days. Everywhere I go, people are saying, ‘There is that property there. There is that land there.’ I think we need a systematic way of capturing the opportunities, because when I go out to see stakeholders I want to talk about opportunities and solutions. When you ask the right questions, people will say, ‘There is that property.’ I do not think we have a systematic way of realising the opportunities sometimes, but this is the time to build that kind of infrastructure to find and bring forward anything possible.

CHAIR: Can I come back to this case management discussion we were having before. Is there anywhere in Australia or the world that has implemented some sort of a case management system for those people who are engaging at a fairly deep level with government services?

Ms Keep: Supportive housing is that. We call it Common Ground, but there are different models of supportive housing. In the US, they have really turned a lot of their investment that was social housing into supportive housing because they have recognised that the people who were accessing that product need support. In Finland they say that they have almost erased rough sleeping because they have invested in supportive housing. I mention Canada as well. In all of these places where it has happened, it is because there is someone in government who has the ability to make change, who believes in this and who understands the economic argument. There is a strong economic argument for doing this as well. They fight for it. They push it through. They make sure it happens. That makes a difference.

Mr MOLHOEK: In our last day of hearings for the Health and Environment Committee’s inquiry into the NDIS and allied health, Kim Rayner from the Queensland Nurses and Midwives’ Union spoke about nurse-led models of care. The figures she threw up were just mind-boggling. She said that basically, just in Common Ground here in Brisbane, the savings to our EDs in saved admissions and diversions were about $6½ million a year, just because of the stabilisation of residents and having that investment of nurse-led care within the community.

Ms Keep: It just requires that up-front investment. It requires us to be proactive. That seems hard. I know the government is managing budgets and all those types of things. You have to invest up-front to get those savings down the track, but the evidence says that they will come.

Ms Caniglia: Data matching would help to identify those people.

Mr MOLHOEK: We have touched on support models for families and about child safety and the long-term impacts. Perhaps you could comment on the impact of multiple placement not just within the foster care system but where we are housing people short-term, stabilising them and then, after a period of time, putting them into the private rental market to fend for themselves. Often, victims of DV have to go through multiple locations and then the kids change schools. In terms of the long-term impacts of that, I would be interested to hear some of the answers around stabilising people in that respect.

Ms Caniglia: Forced moves are really hard on people, and they cost a lot of money. If you are making it in the private rental market but you do not have security of tenure over your life, you do accumulate a lot of cost, affording the process of moving. That is leaving aside the cost of children leaving schools and maybe having to find new connections to neighbours and the kinds of ways people help themselves to be more resilient through their natural helping networks. All of those things can end up being disrupted.

We have also built a housing system, with the best evidence we had at the time, to say, ‘Well, it is an emergency for people,’ so you create an emergency place where they can go. Then you put them into transitional—we had a pathways model—and then they might be ready to go into long-term housing. Most of the world's evidence backs things like Common Ground and supportive housing to say that most people, if not all people, can get into some form of housing as quickly as possible and, with the right support, sustain that housing. Why would support to sustain an emergency housing option be better than applying that support and that physical infrastructure of a home to a longer term solution for people so they do not have to move as much?

If you layer that up on childhoods that have had lots of separations and lots of disruption where attachment is a fundamental issue, we also seem to have designed a system that almost guarantees people cannot form attachments to neighbours and places of belonging. At Q Shelter we favour models like Common Ground that do not only manifest as big buildings and support to that building. It is one model. It is a very important model for economies of scale and getting yields on really good sites. There are also great examples of Common Ground type models in scattered sites, supporting people through all sorts of different living arrangements to prevent those forced moves. If people find a good reason to move, then that transition needs to be well supported. For me, that still sits within a tenancy sustainment framework that, if there is a point of readiness to go somewhere else, then really needs to be done really well if vulnerability is present or the issues can deteriorate again.

Dr ROWAN: Fiona, at page 6 of the submission there is reference to the Productivity Commission recommendation for mental health training for frontline housing workers, real estate agents and others. It is really about first-aid mental health training and other things that could be provided there. Taking real estate agents as an example, when real estate agents go through the Real Estate Institute of Queensland and do their training and certification, should it be embedded in the curriculum there and with others who are providing services in the housing sector? How should that be delivered? What is the mechanism for that? Should that be required through legislation or by working with those organisations to embed it in their curriculums? How could that be done?

Ms Caniglia: That is a fantastic question. We work with the REIQ and do training with them. We have produced a series of products around domestic and family violence. We have seen thousands of private property professionals engage with that learning opportunity. It was not accredited training, but we are now working with the REIQ to embed it in their accredited training. That is one example of how it could work.

Imagine if we bring that level of mental health and trauma informed training to the whole housing system, and I think that is really important. Conversely, I think all of the other types of support, like mental health, need housing first aid. They need the housing literacy, if the other side of the equation needs these other forms of literacy that help it all become an integrated system of delivery. Workforce development is only one part. At Q Shelter we do a lot of training and sector capacity building. Especially when you have investment in new products, you want to see that workforce uplift so that the newness of this funded offering is matched by a workforce that is now working to that new framework and investment.

CHAIR: I would like to thank you all for presenting today. We have agreed as a committee to end your session a little earlier so that we can have a little more time with DVConnect. I am sure that is something you would be understanding of. Thank you all for presenting today. Certainly it will help to inform our report and our recommendations going forward. We all acknowledge the importance of secure housing in terms of maintaining people's mental wellness. Thank you very much.

Ms Caniglia: Thank you for listening.

CHAIR: We definitely appreciate your evidence.

Ms Keep: We have an evaluation report of a pilot project we have been running for supportive housing with families, going back to Rob's question. It has been evaluated by the University of Queensland. It shows the outcomes of diverting people away from child protection.

CHAIR: We would welcome that, if it could be submitted. We did place a number of questions on notice. We would ask for those answers to be back by the close of business on 18 March.

DINGLI, Dr Kelly, Head of Clinical Practice, DVConnect

O'CONNOR, Ms Rebecca, Chief Executive Officer, DVConnect

ROYES, Ms Michelle, Manager, DVConnect

CHAIR: I now welcome representatives from DVConnect. Would you like to make an opening statement, after which the committee members will have some questions for you?

Ms O'Connor: Good morning and thank you for the opportunity to appear as a witness before the committee today. My colleagues and I would like to begin by acknowledging the traditional custodians of the lands we are meeting on today, the Turrbal and Jagera people, and pay our respects to elders past, present and emerging. I also acknowledge those with lived experience of mental illness and domestic, family and sexual violence. Today we are representing DVConnect as the statewide crisis response service for domestic, family and sexual violence. My name is Beck O'Connor and I am the very proud chief executive officer of DVConnect. I am joined by Michelle Royes and Dr Kelly Dingli.

DVConnect helps Queenslanders find pathways to safety 24 hours a day, seven days a week, providing crisis intervention for people, children and their pets experiencing violence; people choosing to use violence; and people and agencies that support them. Forty-one per cent of the people accessing our services are from regional, rural and remote areas across Queensland. As the domestic and family violence crisis response service, we take a call from people impacted by domestic violence, on average, every five minutes over a 24-hour period. We hear directly from victim-survivors about their feelings of constant fear and threat of violence, anxiety, depression, suicidal thoughts, emotional exhaustion, self-harm and often that of their children every day.

Our view is that the psychological impacts of domestic abuse, particularly those as a result of coercive control, are often more dangerous, longstanding and life threatening than most of the physical injuries that occur. Those injuries can last a lifetime and can have ongoing impacts long after a relationship may have ended. Sustained and persistent psychological and emotional abuse is the norm rather than the exception in family violence, with the most shocking statistic of the universal prevalence of coercive control in the lead-up to a domestic homicide.

Today we are here to elevate an under-represented voice that impacts every one of the witness agencies that have participated in the select committee. Domestic violence is one of the most prevalent, pervasive and serious human rights violations and is recognised as a major health and wellbeing issue in Australia, with one in six women experiencing violence by a current or former partner by the age of 15. The link between DV and negative health impacts, including poor mental health and mental illness, is well known. High rates of domestic violence are observed in the histories of those with child and adult psychiatric disorders, with consequences occurring across the life span: child anxiety, depressive and behaviour disorders and developmental difficulties, and later anxiety and trauma disorders; impacts on the developing self and personality; corrosive effects on self-worth and self-esteem linked to passivity, submission and loss of agency; and the inevitability of persistent depressive disorders. Clearly these impacts are immense and can be catastrophic.

We are also here to advocate for a trauma informed approach to mental health responses for people experiencing violence by recognising that many behaviours and responses expressed by victim-survivors are directly related to their experience of living in constant fear and threat of violence and abuse: disassociation or hyperarousal, hypervigilance to the micro behaviours of others and to the protection of their children—which is often misunderstood in the context of domestic and family violence—to a constant sense of betrayal, actual loss of power and voicelessness. The devastating reality is that the prevalence of domestic and family violence and sexual assault is such that with every presentation of a woman to a mental health setting we must think, 'Is this related to violence or abuse?'

We need to get better at understanding how the intersecting systems will operate and how they can continue to perpetuate the loss of agency, do not emphasise a person's strengths and often do not recognise adaptive coping strategies as a result of traumatic stress. We need to have a critical awareness of the power we have as service providers, recognising the individuals as being the experts in their own lives and unique, and think beyond 'one size fits all'. For example, for First Nations people, who are twice as likely to be victims of physical or threatened violence when compared to non-Aboriginal people, a trauma informed healing model of care that recognises the experience of colonisation, discrimination and the intergenerational impact of stolen generations emphasises a more holistic approach and asks the question, 'What happened to you?' rather than, 'What is wrong with you?'

A trauma informed care approach is similarly just as critical to consider for the significant workforce that turns up every day to improve mental health outcomes for Queenslanders. I will now hand over to Michelle to expand on mental health in a DV context.

Ms Royes: As pointed out, domestic and family violence impacts on people's mental health, so to understand and respond to domestic, family and sexual violence you must have a gendered lens. Therefore, we think the same must be true for when we are considering the mental health responses to the community. Why would we need to have gendered considerations? It is so that we have absolutely comprehensive statistics, as Beck has touched upon, that demonstrate the difference in prevalence and presentation of domestic, family and sexual violence between men and women.

Men and women also present differently and to different support services across the mental health service system, including clinical and non-clinical settings. Our responses have to match that presentation and match the way that people seek help. Women who experience domestic and family violence are likely to present to physical health settings with injury because of violence and abuse and, therefore, they will receive mental health assessment or seek mental health support from that environment. Conversely, men are more likely to present in psychological distress and present to other settings.

The combination and the data on how violence is used in families and the differences in the presentation and help-seeking behaviour of men and women demand that we have unique assessment and response models for those differing gender presentations. For example, a challenge in this space for people who use violence, particularly men, is the lack of specialist skill and resourcing that responds to the mental health of men while also holding their violence accountable as a choice. An accountability model needs to be considered in these environments so, yes, the underpinning drivers of violence have to consider and respond to negative mental health and to expressions of trauma based mental health. However, in that we also need to address violence and abuse as a choice. We need to name that and we need to look at the support and referral pathways for those men. When people who use violence present for mental health support, their use of violence can be rationalised by their mental health presentation or not addressed. This in turn limits referral and support opportunities for those men, and this lack of response is not helpful or may even be dangerous for the women and children who surround him. I will pass on to Kelly to conclude our opening statement.

Dr Dingli: Lived experience will tell us that accessing services, including mental health services, after an experience of interpersonal violence and sexual abuse is confronting and challenging. The nature of this type of abuse and violence readily manifests as complex trauma, which in the first instance can be often poorly recognised by mental health services. This can result in misidentification of the presenting issue and lead to a service delivery response that is not trauma informed, thereby triggering an unsafe situation for the person seeking help.

Complex trauma is underpinned by dramatic and repeated violations of personal boundaries and trust. As such, finding trust in these service responses can be extremely challenging. This can result in people discontinuing engagement with services if they are not meeting their needs or becoming deregulated by the system, resulting in a sense of institutional betrayal alongside the personal betrayal the abuse has created. Laying on this the context in which gendered violence occurs within the broader system, that quietens women's voices and uses social norms to hide or excuse abuse—a system that leans towards calling women crazy if their presentations do not map to a typical presentation.

Domestic and family violence causes significant impacts on family and individual wellbeing, including mental health, thereby increasing pressure on the health system overall. During the Roses in the Ocean committee hearing last month we noticed it was emphasised that mental health centric services need to acknowledge the nuances of suicide risk. Similarly, there is a need to recognise mental health presentations and domestic and family violence presentations both in and of themselves but also in the context of each other. DVConnect is not alone in needing this more comprehensive lens. Our existing mental health services struggle to handle crisis responses which are further compounded when co-occurring within a domestic and family violence crisis. Our submission aims to highlight the intersect between domestic and family violence and mental health. When both are present in a person's life they cannot be adequately addressed in isolation. This poses safety risks that may be acute, chronic, episodic and life-threatening.

We advocate for the following to be identified as priority areas in Queensland mental health reform. Of critical importance is how critical trauma is responded to. This requires consistent, recognised and appropriate trauma informed responses of how domestic and family violence impacts and interferes with mental health and mental health treatments. Acknowledging that these treatments can be detrimental to the lived experience of gendered violence, programs and services that can adequately respond to complex trauma are required. Secondly, there needs to be consistent recognition of and responses to people accessing mental health who use patterns of coercive control, violence and abuse through an accountability model. Programs and services that can respond to the co-occurrence of mental health and the use of domestic and family violence, including dual pathways between perpetrator interventions and mental health, are required. Thirdly, we need to create a diverse system that is accessible, with specialised responses for vulnerable groups built on each cohort's lived experience. Our fourth priority focuses on greater support throughout the justice process for female victims and offenders, including counselling and support during incarceration and multiagency responses during transition-out periods. This is particularly urgent and vital for First Nations women. Finally, we ask for consideration and investment in the recommendations of the Women's Safety and Justice Taskforce in tandem with other relevant government investment. We welcome the opportunity to discuss this with you today and take any questions you may have.

Ms KING: I will admit that I almost do not know where to begin. The intersectionality of mental wellness and domestic violence is such an incredibly complex area. I found your submission quite tragic in terms of reflecting on the experiences of women in mental health crises who have their domestic and family violence situations under-recognised and who are being stigmatised and labelled themselves.

When we are looking at people who use violence, men in particular, what do we know about what works? We have heard over and over about the need to build fences at the top of cliffs rather than sit at the bottom with ambulances. I will never advocate for taking ambulances away, but if we are looking at upstream intervention to prevent this barrage of weight of trauma and abuse on our women and children in particular, what can we do to make abusers stop?

Ms Royes: I think a really important part of this is providing services to people who use abuse. Absolutely, first we have to listen to people who are abused and that complex trauma piece. The current systems will respond better if the systems empower women's voices in the justice process. That is one way to improve the accountability framework.

Mental health is a significant presentation. A recent report by the Australian National Research Organisation for Women's Safety looked at intimate partner homicide and the pathways to it. They have identified three particular cohorts. Mental health was prevalent across all of them but particularly in relation to two. The one of most interest was what they labelled deterioration of the acute stress pathway. Of males who killed their intimate partner—females—over a significant period of time, 68 per cent had mental health illnesses that were diagnosed mental health conditions at the beginning of that relationship. It was when there were stressors and their mental health deteriorated after a significant period of time. So they were 'happy' marriages for a significant period of time and then a deterioration point or a stress point became prevalent.

Those people reached out to mental health services, not violence services. At that point the mental health service was unable to recognise or offer support or had no capacity or thinking about responding to these co-occurring statements. Yes, they were experiencing psychological distress, but they often make statements around harm and abuse in the home such as, 'I had to', 'I make her', 'I do not allow her to go out because I feel unsafe', 'I have to control the finances because I'm paranoid about what is happening with our family' or 'I think she's cheating on me, therefore I have to control these circumstances and situations.' Mental health practitioners will hear these comments and sort of let them slide to the side because they are focusing on the mental health, the psychological distress: 'What can we do about your paranoia feeling right now?' I think there is a simple but significant piece of education and empowerment to give mental health practitioners the courage and the right words to name that violence and to start to make a difference right there when that man is in the room.

The second part requires a lot more. We have very poor response systems to men who use violence. We pretty much go from our Men's Line, which is a brief intervention phone line that people can call at any point, to behaviour change programs. The gap between is significant in terms of waitlists, that person's investment and readiness to change, the referral pathways to that behaviour change program, and the suitability at times of behaviour change programs for men who are experiencing significant mental health issues at that point in time. It is often a no-go zone trying to get them to go on the journey of reflection and change when they are not stable within themselves, so we need greater resources in the domestic violence sector but we also need greater mental health services to work alongside those resources.

Ms CAMM: Thank you very much for your submission. I would like to also place on my condolences in relation to what we have seen occur in the last 24 hours, which is nothing short of tragic.

I think you make a really good point about the system and service responses. Recommendation 13 of the Women's Safety and Justice Taskforce, which also drew upon the Domestic and Family Violence Death Review and Advisory Board, found that there are challenges in appropriately recognising and responding to DV that were consistent across agencies and systems. The task force supported those findings around service models being rigid. You outlined the fragmentation and the inconsistency of responses that are more broadly in DV. Can you expand on that in the mental health context? I think we could remove the word 'DV' and put mental health in a DV context and there would be a similar series of deficiencies or recommendations that the task force identified. Where do you see the biggest need for service delivery responses to be reformed? When we layer the mental health impacts in child safety, the key themes I hear are Family Court, child safety, judiciary response and QPS cultural response. Where do you see the greatest need given there is an holistic amount of reform required? When we point to the mental health impacts of domestic and family violence, what do you see as the pointy end that needs to be addressed?

Ms O'Connor: I think it is understanding that for somebody experiencing violence their touchpoint is very often not to a service like us initially; it is where they will often access primary health as their first port of call. I think it is about how first and foremost we understand what a common risk and safety assessment would look like depending on where she—and I will use that language—might access support. It is not only that but also having the confidence to undertake that assessment and to know where those referrals are beyond that—to have a multidisciplinary approach to how we deliver comprehensive patient care, particularly in touchpoints where we know there is greater risk. In maternity care in particular, we find that domestic and family violence, shockingly, can actually first present when she is pregnant. DVConnect, for instance, has done some significant work with the Nurses and Midwives' Union and conducted comprehensive training on how to recognise, respond, refer and report, because we see that is a really critical area.

Conversely, it is how we think about a multidisciplinary approach within domestic and family violence specialist response and how that is informed by mental health practitioners and experts. I think we have seen some exceptional examples of how this can be done in the co-responder model with Queensland police and QAS for mental health. We are seeing the same kinds of really incredible outcomes and responses at that point of crisis by having co-responders for domestic and family violence specialists who are attending. I think that is incredibly supportive for the police to do their job but also to make sure there is that wraparound support. Therefore, we would also think there is a priority to have greater inclusion of mental health and drug and alcohol specialists within a high-risk team environment and to have that more broadly invested across the state, just to begin with.

CHAIR: I want to ask some questions around the intersection of the health system and domestic violence. If a woman is going to present to an emergency room and then be admitted, there is a fair chance that the person is pretty significantly injured. For example, if they have been stabbed, had their jaw broken or been burned, the trajectory they might take through the hospital system will be quite different. My clinical practice is a few years out of date, but I think it would be unusual for a person to have the fact that their injury was as a result of domestic violence listed on their PD list, which is what we look at all the time. It would just say 'stabbing' or 'liver damage repaired through surgical intervention'. Unless they have some sort of obvious symptoms of a mental health issue, there is nothing that would trigger a mental health review for someone who entered a hospital in that situation. Is that still the case?

Dr Dingli: Yes, by and large. You have touched on a very important point. This is an opportunity to identify domestic and family violence risk. There are many areas where things can go wrong when a woman presents with a physical injury. It can be anything from the perpetrator being with her, so therefore how can she safely flag there is risk? That will impact her presentation. Culturally, if she is connected with an Indigenous liaison officer—we all know they are very thin on the ground, so again there is that safety to disclose. Some of the issues that go to what Beck was talking about earlier are that we are often creating an environment where the woman has to prioritise—or the clinician—what need is being met at that time. Is it going to be her physical injury? That is one aspect. Is it going to be domestic and family violence? Is it mental health? In reality, it is probably all of those things. It depends on the clinician on the day, the capacity of the workforce, the referral processes not only in the acute setting but also as she is being referred out, and then also her capacity to realistically and meaningfully engage in referral pathways.

CHAIR: From the point where someone is engaged with the hospital system, we should almost be thinking about automatic health reviews if there is domestic violence identified. I am taking on board all of the difficulties around that.

Dr Dingli: Absolutely, knowing there are so many similar characteristics. This is also true for suicide risk. We know there are a number of commonalities that will be present. It is about having a model of care that allows these things to be explored with clinician confidence at all levels of clinicians and frontline staff.

CHAIR: For men, picking up on the question of the member for Pumicestone, most likely their interaction will be police issuing some sort of an order or, depending on the severity of the situation, some sort of court appearance. At any point in their interaction with the system are there referrals automatically made to mental health services?

Ms O'Connor: That is certainly something we would do. We operate Men's Line, which is a service specifically for men—not only men who are using violence but also men who are experiencing violence. About 80 per cent of the work we have coming in is through police referrals. Police will attend an incident and make an automatic referral through to Men's Line. At the moment there is some court support provided in the Magistrates Court, but that is generally around the process. As Michelle said, and what is really significant, is that there is a voluntary service where we can make contact. So a police referral comes through, but it is still up to him whether or not he wishes to engage. Then we have those conversations, and we will absolutely use that as part of our referral process, but then there can be in some cases up to an 18-month wait before they can even get into a men's behaviour change program. The problem is that all of the supports that he might need to prepare him for that men's behaviour change program are very siloed in terms of financial support, mental health, drugs and alcohol. There is not an integrated approach, so there is this real gap.

There is another important cohort: men who will ring our service voluntarily and self-referral. They will ring up: 'I looked at little Johnny last night and I saw he's looking at me, and I just can't do this anymore. I'm going to ring and I'm going to do something about that.' The evidence suggests that someone's capacity for long-term sustained change is where there is a readiness. The problem is that we do not have the systems and supports. Whether it be backlogs and waitlists through mental health or whether that is getting through to behaviour change programs—there are myriad other things that he needs—we have lost that opportunity. We should be grabbing it then and there, because if I have to say to him, 'In six months we might be able to get you into a program,' or 'We'll get you onto this waitlist for mental health support'—wherever there is a barrier he will just disengage. In fact, all that does is amplify the safety concerns for her and/or the kids because it is like, 'Well, I reached out. What's going to help?'

Dr ROWAN: Thank you not only to DV Connect and Rebecca as CEO but also to your colleagues for all of the work that you do. There is a lot of complexity, as we know, in domestic and family violence, but I want to return to trauma informed care approaches, particularly with adverse childhood experiences. We have heard a lot of testimony from different service providers across different ways of having that trauma informed care approach. Do you think there needs to be a whole-of-government strategy to address trauma and adverse childhood experiences? A lot of these things cut across multiple departments, including health, child safety, education, corrections and communities. If there does need to be a whole-of-government approach or strategy, should that be led by the Department of the Premier and Cabinet? How should that be pulled together? Given trauma related experience or adverse childhood experiences and dealing with that—not only what exists now but also preventive strategies—there needs to be a consideration as to how that is done. My question to you is: do you have any thoughts or recommendations with respect to how a whole-of-government strategy to address that would be done?

Ms O'Connor: We are all going to have things to say. I can see my colleagues furiously writing their notes. Trauma informed care started as a movement from people with lived experience in terms of having their individual and historic presentations coming through, so it is the absolute definition of hearing the voices of lived experience. I would be absolutely in support of that. The other thing about trauma informed care, as you would all know, is that it is about a system. It is not actually a clinical approach; it is about how we use a whole framework of clinical approaches. That has to be something that is understood, given there are so many agencies that have these touchpoints. I could not agree more that that is where we would need to start.

I think we would need to look at that even from the perspective of the way we commission, invest in and fund organisations—organisations like mine or child protection or other services. Even the way we look at what outputs and performances are required of us is not understood through a trauma informed lens—the excessive demand versus the responses that we have to respond to. That in and of itself is really challenging in terms of how we dedicate the time to not only have genuine trauma informed responses but also being able to have trauma informed workplaces and environments for the people whom we are asking to do this challenging work every day. I think it has to start with the way we think we fund this work and what that actually means, making sure there is time for professional development and supervision and training. We have to increase education. That takes time and investment. Contracts do not allow for that. Then we will generally find in services like ours that you push things aside because the client need and client demand and the crisis nature of it will always be the priority. From my perspective, we need to start with how we actually imagine investing in and commissioning work that is trauma informed.

Dr ROWAN: Just to clarify, who should lead that or where should that be led from?

Ms O'Connor: Given the fact there are so many agencies with that responsibility, it should lead from the Department of the Premier and Cabinet, I would suggest, yes.

Ms Royes: To reflect on something that was raised with the last panel, our Brisbane Housing colleagues spoke about how they did vigorous advocacy to get a great outcome. Having the time and capacity and energy in your workday to do that is worth more than a great IT system. Yes, there are great things that we can pull from technology. We are definitely on that train as a virtual service. We are constantly reviewing and updating our technology to see how can we do it better and more efficiently with less admin, but you still need advocacy. You still need to figure out the right way for that client, to give models that give us that space to say, 'What's happened to you?' That is especially so when women present with significant injury in hospital. They are often disregulated. They can be hard to triage. It can be hard to be the perfect victim who wants help and treatment. You bandage them up and they run out the door. What are they not getting from that help-seeking? We have to follow the help-seeking. People reach out where they reach out, so let's build a system that connects with where they reach out and what they want. Yes, we get police referrals. Yes, we can refer to mental health systems. We can refer to DV responses. There are problems in those areas with resourcing, as Beck has pointed out, but they do not always connect with that. A police referral involves an incident, but so much violence and abuse involves no incidents, involves no police.

Again to reflect on the *Pathways to intimate partner homicide* report, two of those cohorts are not really known to justice systems, yet they are taking up 60 per cent of the deaths that have occurred, so we have to look outside the DV system to help prevent DV. I think it is looking at ways people present. So just give everyone an extra position, bare minimum.

CHAIR: We just received a request on notice for that report to be provided.

Ms KING: Can you provide the committee with the report *'Pathways to intimate partner homicide' project: key stages and events in male-perpetrated intimate partner homicide in Australia*?

Dr Dingli: Absolutely. The current system is not set up to give an accurate picture of where the burden sits because of multiple presentations—people being bumped from system to system because of vulnerability and vulnerability. It can only have benefits for creating—financial, of course, which we have to consider—that integrated system for the person. We can then adequately allocate where the funding and resources need to go if there is that common language and approach. That is also the only way we will embed the cultural change that is needed to support it.

Ms CAMM: My question relates to your organisation and the potential risk of secondary trauma and mental health prevalence when you work within the sector. Under your existing funding arrangements, are you adequately provided for to provide that level of support to your own workforce? Can you expand on how you support your workforce and their mental health? If there is best practice around that, can that be taken as a recommendation for the sector more broadly?

Ms O'Connor: The first thing I would like to say is that we talk a lot about vicarious trauma in the work that we do. What we do not talk enough about is vicarious growth. What is really important in terms of the way we respond that is important for us is, firstly, the principle that our clients do not make us sick. It is an absolute privilege to do the work that we do and to be exposed to courage and bravery and resilience every single day. I think it is about making sure there is balance in terms of that, first and foremost. We invest heavily in making sure there is supervision available with a structured supervision model. We use a PACE model, and that is done pro rata in terms of the amount people will actually work. None of your staff at the front line will work full-time. There are a maximum number of shifts that we will have people work to help provide some of that balance.

There is regular coaching and one-on-one sessions. There is structured professional development, and we have an investment in what we call health and wellbeing activities in the office. That can be everything from a yoga class to clothes swaps. Food is the love language in our office. One of the things people will note when they come to DVConnect is that they come in expecting it will be chaotic and crisis driven, because that is the work that we do, but in actual fact it is a really calm environment because that is our role. Our role is to be the calm in the crisis. The thing about a trauma informed model is that it is about collaboration, choice and empowerment, and those are very much the values of our organisation and how we like to lead from a position of consultation.

In terms of your question around whether we are adequately resourced, at the moment we are fortunate to be receiving additional funds due to federal investment through COVID special funding. That has been incredibly important in terms of being able to provide not only these kinds of supports to our staff but also flexibility to change the way we work due to COVID. That will be ending, so there are significant concerns about what happens when that funding, which is only temporary, finishes at the end of June.

CHAIR: I would like to thank you very much for your presentation here today. It will certainly help our committee with its report and our recommendations. On behalf of committee, I would like to thank you for all the work that your organisation does and all that your staff and volunteers do. It is tremendous work in our community. I am sure we are all committed to ensuring that we can continue to say ‘not now, not ever’ to domestic violence.

Proceedings suspended from 11.00 am to 11.34 am.

BAMBRIDGE, Mx Caitlin, Senior Policy Adviser, Suicide Prevention Australia (via videoconference)

McLEAN, Mr Matthew, Director, Policy and Government Relations, Suicide Prevention Australia (via videoconference)

MURRAY, Ms Nieves, Chief Executive Officer, Suicide Prevention Australia (via videoconference)

CHAIR: I ask you to make a brief opening statement and then we will go to the committee for questions. We have read your submission. Thank you. It was a good submission.

Ms Murray: Thank you for the opportunity to give evidence to the parliamentary inquiry and to have the opportunity to improve mental health outcomes for Queenslanders. On behalf of Suicide Prevention Australia I am pleased to contribute to this inquiry along with my colleagues.

As the peak body for suicide prevention in Australia, our organisation represents over 400 members working to prevent suicide across Australia. Our members comprise service providers, practitioners, researchers and community leaders. Among them are the largest organisations in the area of suicide prevention through to many grassroots entities all over the country.

In Queensland we represent over 20 organisations as diverse as the Australian Institute for Suicide Research and Prevention, multiple primary health networks, Mates in Construction, Roses in the Ocean and yourtown, who administer Kids Help Line. We are proud to also have 20 members that champion suicide prevention across Queensland. We exist to provide a clear and collective voice for the sector and, with our members, work towards the ambition of a world without suicide. Every year over 3,000 Australians die by suicide and over 65,000 Australians attempt suicide. In 2020, sadly, 756 Queenslanders lost their lives to suicide.

Suicide is complex, multifactorial and very complex human behaviour. It is more than simply an expression of mental ill health. Factors that contribute to suicide may include stressful life events, trauma, mental or physical illness, financial and job insecurity, social isolation and relationship breakdown. For this reason, we have sought to contribute to your inquiry. As a national peak body for suicide prevention, we strongly advocate for the committee to consider the shared and distinct challenges, opportunities and priorities for suicide prevention in Queensland.

Our submission focused upon building upon the state’s commitment to a whole-of-government and whole-of-community approach to suicide prevention outlined in the state’s suicide prevention plan, every life; strengthening and expanding existing services and programs to achieve equity of access across the state so that every Queenslander can receive the support they need when they need it; and looking to the future by enhancing protective factors for suicide, given that the link to suicide is evidenced in disasters.

There is work to be done within our health and mental health systems. Issues of access, equity and efficacy are real. Challenges of workforce, funding and outcomes are persistent, but that is only one side of the coin. Only half of those lives that we lose to suicide each year in Australia are accessing mental health services at any time. Around half of those who die by suicide each year have a diagnosed mental health condition.

A YouGov poll in 2020 identified social isolation and loneliness, unemployment and job security as the key factors driving distress over the next 12 months. Only by addressing the risk factors of suicide led by a whole-of-government approach and a whole-of-community approach can we turn the trend towards zero suicides in Australia and in Queensland. There has been progress made in recent years, but there is much more to be done. This committee has an important role in improving the mental health and wellbeing of Queenslanders. It can shine a light on the challenges and progress, and it can progress the opportunities for suicide prevention right across the state. It could not be a more important time to address this issue.

Recent events such as flooding and the ongoing COVID-19 pandemic have demonstrated the need for resources to be available to respond in real time to multiple and compounding disasters that leave many Queenslanders vulnerable to the risk factors of suicide. As we know, the risk of suicide is often elevated two to three years after a disaster event. We have seen that with cyclones in Queensland in the past. These immediate supports are critical, as are sustained, ongoing investments. We look forward to answering your questions.

CHAIR: One of the psychologist organisations was here yesterday—and I pick up on your recommendation around the need for more counselling and supports after disasters. The suggestion was made that perhaps these things should be triggered by a natural disaster declaration, just like a whole lot of other things are triggered when we declare a natural disaster at either the state or the national level. Would it be your view that we should automatically include some sort of counselling or other suicide prevention mechanisms in a disaster recovery?

Ms Murray: I think it is fair to say that counselling is just one solution. Protective factors in relation to suicide prevention involve a much broader range of services and supports for the community than counselling services. We certainly have seen an increase in utilisation of crisis support lines as an example during the COVID-19 pandemic and during other disasters. Often it is two to three years later when those protective factors and community supports start to be wound back that we see changes and increased distress in the community—things such as financial support, not just counselling and psychological support. I might turn to my colleagues, perhaps starting with Matt and then Caitlin, to further expand on that.

Mr McLean: Our view would be that it is important that counselling and other support services are there and they are sustained. As to whether the disaster declaration is the appropriate trigger, if that delivers quick and sufficient supports then we would support that. We expect it is also a matter of having this built into disaster planning and preparation beforehand. One of the things we have advocated in our submission is having some of those discretionary funds set aside in the budget each year so that, regardless of what type of natural disaster might strike or when and where it might strike, we have no delays in getting those funds for counselling or for coordinating with our lifeline members as well as some of those ongoing supports in the community that Nieves has outlined. We would not have an issue with that being triggered by a disaster declaration, but I think there needs to be some preparatory work before that as well. Caitlin, do you have anything to add on that?

Mx Bambridge: I think that is completely right. The main point we want to drive home is that, yes, we do need a recovery response to disasters that addresses suicide prevention, but we also need to be proactive in our suicide prevention responses. Instead of the historic reaction, which has always been reactive—so once a disaster hits—in our recommendations we have called for ensuring there is money for increases in helpline calls, to make sure that money is available and ready to go to support our services that currently exist to respond to disasters at the time they occur.

CHAIR: I want to ask a couple of questions around safe spaces. The commission talks about expanding safe spaces. Do we have them in Queensland? If we are going to expand them, where do they need to be? How many do we need? What do we need to do in terms of rolling those out?

Mr McLean: There are a number being trialled in Queensland. There was a $10.8 million commitment made a couple of years ago to roll out eight safe spaces, and one of our members who has a particular focus on lived experience, Roses in the Ocean, has been working with Queensland to roll them out in different parts. To go to your question, they are needed not just on a trial basis but in all our communities. One of the real virtues of this model is that they are a cost-effective and very quality alternative to emergency department presentations.

I think there is clear consensus amongst researchers, clinicians and people with lived experience—survivors of suicide attempts themselves—that the clinical setting of an emergency department is an unacceptable place for people at that point in crisis to be. It does not lead to good outcomes at the individual level. It is incredibly expensive at the system level. What the safe space or safe haven alternative does is provide a more comfortable, more caring and compassionate environment for that individual to present to. We have seen a number of models trialled overseas now, whether that is a drop-in cafe or a centre staffed by peer workers—so people who have lived that journey themselves—but what we are seeing all over the country, with trials in New South Wales and other jurisdictions as well, is that they really provide a valuable alternative—one that can save dollars but one that, importantly, can save lives because people are feeling very comfortable to present there.

We have been pleased to see that $10.8 million commitment on a trial basis, but we would like to see that rolled out more broadly, including in regional and rural Queensland and in a number of different levels. The safe spaces can range from that drop-in refuge point of view, a library, a coffee shop model, all the way through to a peer-run residential house that an individual might need to stay in for a few years.

CHAIR: This is a practical question with regard to how they operate. There are going to be people whose suicide attempts will require them to be seen in an emergency department because they have physically damaged themselves to the point where you need to take those interventions to save their life. I am reflecting on the people I have cared for who have attempted suicide. As you would know, there are lots of different triggers and categories and ways that people attempt this. However, it seems to me there is a fairly large chunk of people who are not necessarily going to think, 'Oh, I'm about to put a rope around my neck because I've had a fight with my girlfriend and I'm going to hang myself. I better go down to a safe space cafe.' The question I am trying to drive at is: how do people get to these safe spaces? How do we embed them in the community in a way that people know they are there so that they think, 'Rather than taking that drastic action, I should perhaps go down here where there is somewhere safe and I can get some help and care'?

Mr McLean: You have touched on a very important point. Safe spaces, like a lot of measures in suicide prevention, are just one part of the solution. By no means is this the silver bullet that solves any issue of suicide attempt or drives us unilaterally towards zero suicides. People who have reached that point of distress or have made previous suicide attempts know that these spaces are available, perhaps through their clinical and psychological treatment which has made them aware: 'If you're feeling these thoughts of suicide ideation, you might want to drop in here.' They are a part of that solution.

I think one of the important things to note about this model is that they are fundamentally designed in partnership with those who have lived and living experience. You work really closely with people who have been at that point of crisis themselves to know, 'What is the right location for this?' We have seen some failed attempts, where it is actually just a room next to the emergency department that really does not work in providing that genuine alternative. What is the branding and awareness campaign? You do not wrap it up like typical Queensland Health branding information. How do we get it out to peer workers? How do we get it out to people in need? It is an important part of that suite of services available to those in crisis, but it is not the only one.

Ms CAMM: Thank you for being with us today and thank you for your submission, which was extensively covered. I come from a regional community in the Whitsundays and Mackay region. While this was probably covered off a little bit in your submission, I am very keen to understand your thoughts, as the peak body, as to the fragmentation that exists across communities in this space. We have a lot of well-meaning, quite often trauma informed not-for-profits or charities that have been born out of normally a very traumatic situation—someone has lost a loved one through suicide or lived experience—that then start up some form of either education or support service that falls under a banner. I know that across my community there would be 30 or 40-plus different service providers that would fall under what is a much broader banner of suicide prevention. What are your views on how best these organisations can be utilised in a collaborative model? Do you think there is any role at all that governments play in reforming or ensuring there is a set of practice principles or a framework around this? I will give you context. My biggest concern is that it is a very confusing space for people to go to and get the right support that they need at the right time, and the unintended consequences are that potentially people are falling through gaps or are not getting the expertise that they need.

Ms Murray: Certainly we have a lot of involvement with the Whitsunday Suicide Prevention Network. They are a very active member of Suicide Prevention Australia and a participant in our Queensland joint committee, so I am very aware of the situation in the Whitsundays particularly, and in particular some of the experiences that have occurred in that area post natural disasters. The question you raise is a very valid one and one that has been in fact a topic of conversation at the federal level for a number of years. The role of coordination and ensuring efficacy of programs has been exercising our minds for quite some time.

In recent years, Suicide Prevention Australia, in conjunction with the rest of the sector, have developed a series of national standards that currently form part of an accreditation program. One of the things we are working on with the federal government in particular is how we ensure that programs which are funded to provide suicide prevention services meet those standards and ensure that all programs that are funded are either going through the accreditation process or have completed that journey. That is one mechanism that the government can utilise in ensuring there is better coordination and better collaboration in the way that programs are being funded.

As you rightly say, often we see services spring up as a response to a crisis, as a response to grief, as a response to trying to do the right thing, by a community that does not lead to effective and well-coordinated services for people on the ground. The accreditation process is one way that the government can ensure that, as they fund programs, those programs are meeting a standard and also are required to collaborate with other programs in the area. I notice that Caitlyn is nodding. I wonder whether, Caitlyn, you would like to add to that.

Mx Bambridge: I was nodding because you said that very well. Matt, do you have anything you would like to add?

Mr McLean: I agree with what Nieves has outlined. One of the things we are really conscious of as a sector and as a peak body is that we are seeing increased funding in suicide prevention services—not enough, I would say, but we are seeing a tracking in the right direction. We need to make sure that those funds are flowing to safe, quality and effective services. The other point you went to is around how people navigate those complex services. That is a really important piece of the puzzle as well, particularly in what is a complicated federal structure for suicide prevention and mental health where we are seeing different investments made at the state level as well as at the national level. We are very optimistic that the national agreement that we understand could be back in national cabinet as soon as this afternoon goes some of the way of reducing that duplication, increasing that coordination and really driving what is for essentially the end user an easier to navigate and highly effective mental health and suicide prevention system.

Mr O'ROURKE: Thank you for your submission. One of the recommendations in your submission is enhancement to strengthen the follow-up procedures for people discharged into the community after a mental health or suicide related presentation. We have heard from other witnesses around NDIS funding being very much targeted to those very vulnerable people. On the ground, how do we better link some of those services, or where are those services for people who are not in the NDIS system, and how we can enhance service delivery?

Mr McLean: It is a really important question. We know that those who attempt suicide are the highest risk group for a future suicide attempt and, tragically, for a death by suicide. We know that there is a critical window, particularly at the three-month mark after a suicide attempt, for getting the right services for those people who need it when they need it most which will save lives. To give you an example, each year we know that around 65,000 Australians attempt suicide. As it stands now, only about half of those, once discharged from the emergency department, will have aftercare support—that follow-up clinical and non-clinical support in the weeks and months following a suicide attempt.

There has been a commitment at the federal level to universal aftercare so that every Australian, once discharged from an emergency department and other settings, will have that support. That has been negotiated by states and territories as we speak. This week we have seen New South Wales reach agreement with the Commonwealth to ensure universal access. We really hope that Queensland and the Commonwealth can reach agreement as soon as possible so that everyone can have access to the supports they need when they need it. What that looks like on the ground is: once someone is discharged from that emergency department, within hours or days they have follow-up calls from a service provider, a counselling service available, but they also have some support in a non-clinical sense so they can reconnect with their community and they can keep up some of those social supports, which can really be fractured after a suicide attempt. It is addressing not only their immediate clinical needs but also making sure that their recovery journey lets them stay a part of their journey and access some of those social supports that we know can be such an important protective factor for any future attempts.

Ms KING: Thank you very much to all of you for taking the time to be with us today and thank you for your very extensive submission. I have a couple of questions about your submission. Firstly, you recommended that the Queensland parliament pass a suicide prevention act. Could you outline what you envisage that proposed legislation would encompass and why that is important to you? Why is it important and what would it cover?

Mr McLean: We think this is a really important recommendation. It is important because, as Nieves outlined in her opening remarks, suicide is not just a mental health issue; it is complex behaviour. Of those who tragically lose their lives each year—over 750 Queenslanders—only half were accessing mental health services at the time. We will never achieve our vision of a world without suicide if we are only looking at the mental health and health system. That is an important part but only one part of the equation.

What a suicide prevention act does—we have seen it work overseas and we are really pleased to see South Australia pass bipartisan legislation in November—is build that whole-of-government focus. It ensures that other agencies—whether it be family and community services interacting with people who are at a heightened risk, housing departments or education departments, where young people are a key priority cohort—have clear plans and accountabilities to think about suicide prevention in what they do. It is really to be the neck that turns the head of bureaucracies towards what they can do for suicide prevention in their area of service delivery, in particular in the social and human services.

CHAIR: I would like to thank you for the evidence you have given here today and thank you for taking the time to make a submission. I would like to thank all of your members, volunteers and staff for the work they do in this space every day. Certainly your presentation has helped us to understand a bit more about the issues and will certainly inform our committee's recommendations and reports going forward.

BRAY, Ms Megan, Dietician and Senior Mentor, Eating Disorders Queensland

CHELIUS, Ms Belinda, Chief Executive Officer, Eating Disorders Queensland

MARSHALL, Ms Rohie, Care Navigator and Public Health Lead, Eating Disorders Queensland

CHAIR: Could I ask you to make a really brief opening statement and then we will go to questions. We have read your submission. It was good.

Ms Chelius: I am the CEO of Eating Disorders Queensland. I am also a social worker, back in the day, by trade. I first would like to acknowledge the traditional owners, the Turrbal people and the Jagera nation, whose lands we are on today.

EDQ shares the recovery wisdom and we aim to improve people's lives by including the lived experience of carers, families and loved ones. We celebrate the extraordinary diversity of all bodies, genders, sexualities, capacities and relationships that we as a community represent. We especially respect all those in the community who have tirelessly advocated for positive social and political change, particularly around women's issues and children's issues around sexuality, sexual abuse, domestic violence and changes to the LGBTI community. I also want to do a shout-out to the two lived experience women who testified yesterday and shared their lived experience of an eating disorder. We hear you and we support you. They are going to be a hard act to follow. To my EDQ team, tireless workers in the field, we cannot do this work without those practitioners.

Just a little trigger warning: we will be talking about weight, numbers and compensatory behaviours so, to everyone who is listening, it might be triggering for their recovery. Rohie Marshall is our key navigator and our public health lead with a lived experience and she will talk to you about the public health messaging that we find incongruent at the moment. Megan Bray, who is a dietician at Eating Disorders Queensland with her own lived experience, will also talk to her lived experience and about being a practitioner in the field.

Thank you for inviting us to have this conversation. We are passionate about eradicating weight stigma and diet culture. Thank you for giving us this opportunity to have a conversation. The Productivity Commission report did not really touch on complex mental health, especially eating disorders and the widespread experience of body image issues within our community. EDQ is a statewide community based not-for-profit organisation. We are primarily funded by Queensland Health. We do provide the largest not-for-profit community support in Queensland to individuals and families living with and impacted by eating disorders. Like I say, we are extremely passionate about debunking the myth around weight stigma and diet culture. That is our soapbox. We want to eradicate that completely.

We occupy a very unique space in this broader eating disorder system. Eating disorder treatment has predominantly been through a purist medical model. Yes, there are high physical risks to having an eating disorder. We, however, sit outside that purist medical model and we have developed an integrated model of care that fits seamlessly into the stepped care model of treatment alongside clients' medical treatment teams. Our practice framework is essentially community, warm welcoming, belonging, safety, generosity, connection, authenticity, relationships, compassion, acceptance, social justice and inclusivity with a very strong feminist practice framework, which is diversity, equality, accessibility, valuing lived experience and anti-oppressive and then sustainability, wellness, enjoyment, fun, communication, adaptability and a flexible response to our clients' needs.

Since 1996 EDQ has developed, as I said, this unique model of care. We are funded through Queensland Health's Connecting Care to Recovery under community treatment services. That plan expired in 2021. That plan only mentioned eating disorders specifically for CYMHS back in the day. That was the only specific mention of eating disorders. We have now been funded under Shifting Minds, which ends in 2023. We are awaiting a new plan. Therefore, our funding is in a holding pattern right now. I am trusting we are going to get additional funding. We do not know how much. What I hear is there is a hold-up between the national plan and the state plan, which again leaves communities like us in a holding pattern. It is really frustrating to say the least, but I could be corrected here; I am not at the political table. We were really privileged and grateful that we got a COVID-19 one-off telehealth grant. We also got ongoing funding that translated into enhancement funding under Shifting Minds. That was the most efficient funding—

CHAIR: We only have half an hour. We have a lot of questions we want to ask. I am sorry to interrupt.

Ms Chelius: Should I just wait for your questions?

CHAIR: If there are some key points that you want to make, otherwise we are going to ask you a lot of questions.

Ms Chelius: The point is that we are a system that works really well together. We work the system to the bone. We have no resources so we are asking for early onset money to treat those clients who are coming into the system quicker and earlier to negate the long onset of eating disorders. That is just the nuts and the bolts of it. It is such a complex area that I do not know where to stop.

CHAIR: We could spend a whole week talking about it and still have things we could say, I am sure. Let us start there. From a clinical perspective—and I am sorry to take that approach but that is how I think—you have developed an integrated care model. I am aware of that because you used to be based in Greenslopes and then you moved away, sadly. There are evidence based treatments that can be rolled out for all types of eating disorders with good prospects of full recovery; is that fair to say? Is that accurate to say?

Ms Bray: Yes, there are evidence based treatments that are effective for the majority of people with presentations across the diagnostic spectrum. One issue though is at the moment it is focused on anorexia treatment. We actually know that the most common presentations are binge eating disorder, or what is called other specified feeding and eating disorder, and this tends to occur in people of a 'normal' or higher weight so it gets missed a lot. This is actually the cohort that has the best chance of recovery.

CHAIR: Are people currently missing out on services because there is simply not enough services out there? I know of people in my electorate who have been seeking support and have not been able to get it.

Ms Marshall: Yes, definitely. I work in a peer support group. One of the most common things that we end up talking about is how hard it is to access treatment, how people are consistently being turned away from services because practitioners are not comfortable treating them because of long waiting lines or expense or because their BMI does not meet the criteria for that service.

CHAIR: I am aware of people who have travelled overseas quite frequently for treatment because they have the means to do that obviously. There seems to be quite a significant link between untreated eating disorders and suicide. Would it be fair to say that if we put more money into treating eating disorders we could have an impact on the suicide rate for people with eating disorders?

Ms Chelius: People with an eating disorder are three times more likely to have suicidal ideation or actually have a plan. The complexity of an eating disorder is exactly that: it comes with all those other co-occurring manifestations of mental health. The impact of an eating disorder across the sector is so unknown and some of the rates are higher than depression and anxiety, but because of the stigma attached to it—like it is a lifestyle choice, you can choose to eat something—that stigma then prevents people from actually stepping up and getting the treatment that they need, especially if they are in a larger body.

CHAIR: I wanted to come to that point next before I hand over to the members for some questions. We have been talking about treatment for people who have been diagnosed or identified with an eating disorder, but a big part of your introduction—and I know from reading your submission and other work of yours that I have read—is that work you want to do around changing cultural attitudes towards diets and weight. I assume that is more in the sort of preventive space and trying to have a healthier approach to life. Could you comment on what needs to happen in that space and if there are barriers to it happening at the moment?

Ms Marshall: Yes, definitely. I think working in that prevention space is critical and it is something that we do a little bit of, but obviously it is not our primary focus. One of our big concerns at the moment is that a lot of the public health messaging is very focused on obesity. There is a lot of evidence that says that that is directly leading to disordered eating and eating disorders. I think we can move away from that obesity messaging. One of the key recommendations of the federal obesity select committee last year was not using the term 'obesity' anymore because it is so stigmatising and shaming. It is moving away from that messaging or at the very least including eating disorder expert consultation in the development of public health campaigns in the prevention space would be important.

CHAIR: From a clinical perspective, there is a point where your weight can become an exacerbating factor in a range of health conditions. What is the messaging that we need to put out there to try to address that, but not cause other problems in the interim?

Ms Bray: At the moment, a lot of our messaging around higher weight individuals is to eat less and move more. We focus less on health behaviours. We know things like dieting as a way to lose weight is ineffective for 95 per cent of people. There are actually interventions that can be protective for both people at risk of developing an eating disorder and people of higher weight. Usually I like to think of it as more of an additive approach rather than an approach about what you take away. There is a lens through which you can kind of meet both people's needs.

CHAIR: Have you engaged with Health and Wellbeing Queensland around the work they are doing around obesity?

Ms Chelius: We have had conversations.

CHAIR: Are you able to outline how those conversations are going?

Ms Chelius: It is cordial and they are hearing us. I do not think you can have a program called ECHO that actually has obesity in the name and then prescribe foods that are deemed as—they do not use the wording 'bad' or 'good' food, but that labelling of good and bad food, attaching morality to food, is what our young people immediately attach themselves to. If we look at the Wesley survey for young people, every year body image issues is No. 4 on the list. In 2021 it was the same—body image issues. It is higher for people who identify as Aboriginal and Torres Strait Islander. Our young people are hearing the messaging, 'There is something wrong with the choices you are making around food,' rather than including a health behaviour.

We are talking about eating food across all ranges and not being weight centric. You can be healthy without making weight the centre of your messaging. It is about movement, the variety of food, your alcohol intake, smoking—all that basic health messaging. It is about moving away from being weight focused. When it is weight focused and people show up at an ED where the practitioners might not understand eating disorders, the immediate reaction is, 'You are not underweight. Therefore, you do not need to be addressed or scanned or assessed for an eating disorder,' and I think Megan can speak to that because it is her lived experience.

Ms Bray: It is incredibly common for people; that was my experience. I was quite overweight when I was younger and I presented with an eating disorder, but the messaging was very much like, 'She's now just dropped weight into a healthy weight range. We will just watch and see what's happening.' This was despite asking for lots of help. Ninety-four per cent of people with an eating disorder are not underweight. There is evidence to suggest that 30 per cent of people accessing weight loss services might actually meet the criteria for binge eating disorder. There is this massive overlap.

We also know about the social determinants of health and obesity. Our society puts a big focus on what the individual is going to do to change their weight. There is so much evidence around the social determinants of obesity as well that really need to be considered in all of that.

Dr ROWAN: Thank you to eating Disorders Queensland for all you do. As a specialist physician I have cared for patients but also have a family member who had anorexia nervosa and I have seen the other side. It was a long two- or three-year journey, which was enlightening. Having been a physician and provided care on that side and then being involved in the other side gave me immense insight. I again acknowledge the work you do in supporting people. I come back to the weight stigma and the diet culture—and I have a daughter who is now 12, turning 13—and what is happening in social media, particularly around those things. I have two questions. What further needs to be done in that space? Obviously there are a lot of things that I see that we are constantly managing amongst school populations around weight stigma, diet culture, the modification of images in social media and all those things. That is probably the negative side of social media. On the positive side, are there things that can be done? I am picking up on the points of the chair when he spoke about Health and Wellbeing Queensland. Is there further room for healthy and positive messages getting into social media and things that can be done through our schools, community and sporting organisations, through Girl Guides, scouts and others to counteract the weight stigma and diet culture? Can there be better messaging through all of those things? If there is, how should that be done in Queensland?

Ms Marshall: There is, as you mentioned, already great movement in improving social media and working on how images are modified and the messages that are being sent through social media. There is a lot of room for preventive programs that are based on positive messaging. For us, it is about building connection and community that is not focused on body image or weight but is just about supporting each other and essentially replacing all of that time spent on social media and hearing those messages with time spent connecting with others and building up your self-esteem.

Ms Chelius: We primarily fund it as a treatment. Our funding does not extend to early intervention but rather early onset, which is a big ask for us around funding. In terms of early intervention, we have developed our own schools program. We actually go into schools, do presentations and get the children involved in school projects, such as running their own little campaigns. Again, it is about resourcing. Queensland Health is not in the business of funding that for us because we are, like I said, primarily a clinical team. PHN has given us some psychosocial money. Again, the issue with federal funding is that if you sit in the north you cannot get what the south is getting. If the south is getting it then the north cannot get that. There is perhaps room around how PHNs work and funding, especially for an organisation that is statewide like ours.

Ms Bray: I was going to add one thing. As a dietitian, it is about how they align the curriculum. Kids still get sent home being asked to track their food and monitor their BMI at school as part of learning about ‘health and fitness’. We can be supporting people to eat more nutrient-dense foods rather than focusing on tracking things like our weight. There are interventions that, again, can improve people’s health across their lifetime but also decrease the risk of eating disorders in schools.

CHAIR: Out of interest, what percentage of people are diagnosed by their GP with an eating disorder? Are there places for the GP to refer those people to?

Ms Bray: At the moment there is a four-year delay from when people start engaging in eating disorder behaviours and when they are first diagnosed. No slight on GPs; they are incredible. However, as a clinician in the space, week after week I am watching people who have had their eating disorder for many years but who are not referred on. This is causing greater severity and greater chronicity of eating issues. There are places to refer, but at the moment you are looking at a six- to 12-month waitlist for a lot of services and it is very difficult to find available practitioners.

Ms Chelius: We have a nine-month waitlist. On the subject of GPs, we have amazing GPs who work with us, but it takes time to assess somebody for an eating disorder and it takes time to actually learn what to look for, especially if the patient presents in a larger body. There are resources for GPs, but it is about them having the time to actually do that training. We all know GPs are time poor, unfortunately.

Ms KING: Thank you for your work with and for people who experience eating disorders and all of the misery that that can bring into their lives. Thank you for your expressly feminist approach to these issues. I very much appreciate it. Can you talk to us a bit about what is missing in terms of services for people experiencing eating disorders? What would make their lives, their trajectories and their potential recovery better, quicker and easier if it could be provided?

Ms Chelius: It would be getting into the services quickly. If it is an early onset of an eating disorder, it would be getting in before three years, before the brain plasticity changes. That excludes people with complex trauma. Ideally, we do our own assessment and try to get clients in who are probably younger and have an early onset, and we say three years. Like I say, our waitlist is nine months—it is just scary—but we try to triage them to come in earlier. It is about resourcing the system.

What we do works. What Eating Disorders Queensland does and what QuEDS, the hospital and health service—we work very well together. It works; we are just underresourced. Since the pandemic we have had 77 per cent more clients. That is not just the sessions, not just the hours; it is clients presenting. Ninety-eight per cent of clients come through hospital and health services with higher acuity than a community organisation ideally would be seeing, because we are supporting the HHS to avoid hospitalisation.

Ms Bray: As a clinician, it is a pleasure to treat an early intervention case. You get that person in and they are out quickly, whereas the average eating disorder duration is seven to nine years if we do not act quickly. When you look at the literature around eating disorders, that is the best chance we have.

Ms Chelius: It is about early onset.

CHAIR: I have seen in a number of other submissions the statistics on the increases in eating disorders over the past few years. Is there any indication as to why? Is it better surveillance? Are there other things that are leading to this?

Ms Bray: There is certainly evidence that the pandemic has increased eating disorder presentations. There has been increased funding federally for eating disorders that has made a really big difference as well, but there are still opportunities for more people to be seen.

Ms Chelius: I think public messaging might be helping, that people are coming forward. I always say, in our experience in Eating Disorders Queensland, the pandemic has been a perfect storm. If you isolate people who have food insecurities and people are socially disconnected, you create a perfect environment for an eating disorder that is a secret issue.

CHAIR: The private hospitals presented to the committee earlier. They mentioned that they do a lot of work in the eating disorder space. Does your organisation work in well with them? You mentioned the HHSs, but what about Belmont, Toowong and those sorts of places?

Ms Bray: They do not have specialist eating disorder programs.

CHAIR: What about Ramsay?

Ms Bray: The New Farm clinic does and then Gold Coast and Sunshine Coast. As far as specialist eating disorder programs go, a lot of the time we have to refer to a different catchment area. Yes, we work with them.

Ms Chelius: Also when those clients become unwell they are escalated to the Royal to do renourishing. If they are medically unstable they are referred.

Ms CAMM: That leads to my question. Are there any specialised services outside of the south-east corner? I am from North Queensland and Central Queensland. Outside of Queensland Health, are there any specialised beds or services?

Ms Chelius: There are five beds in the whole of Queensland, which sit at the Royal. The other patients go to medical to get renourished. Then we have North Queensland QuEDS, which is HHS. They do some case management and assessment. There is the new residential Wandi Nerida on the Sunshine Coast. That has 13 beds, but they are not funded by Queensland Health. I think there is a little bit of discussion as to what the Commonwealth should pay. There are 13 beds there, if people can afford to go into that facility.

Ms Bray: North Queensland is notoriously difficult to access for eating disorder presentations.

CHAIR: I have a question that the question from the member for Whitsunday triggered for me. In the area of alcohol and drug rehabilitation or treatment we have what you might call shysters out there selling snake oil, but you have desperate people who are prepared to give it a go. Do we have some similar challenges in the area of eating disorders, of people offering treatments that may not be evidence based?

Ms Marshall: I imagine not as much as in the AOD sector.

Ms Chelius: We do, yes. I think what has happened—and it is a great move—is we have 40 sessions through MBS. That has created a lot of people going into private practice. Treating a client for 40 sessions makes business sense as well, but some of those are not credentialed or experienced. There might be charities that feel that they want to do something different. In general, as an eating disorder sector we work very well together.

Ms KING: Can you tell us briefly about the role of a lived experience peer workforce in eating disorders?

Ms Marshall: We believe it is very valuable. You would have seen that our organisation is really built on that concept. Lived experience speakers like me can offer hope to individuals with eating disorders, their loved ones and their carers where there may have previously had none. They may have never met somebody who has had an eating disorder and recovered. We are also able to provide really valuable training to health professionals.

Ms Chelius: We have a dedicated peer mentor program.

CHAIR: Can I ask you to table the document you wanted to table?

Ms Chelius: Yes. It is all of our statistics.

CHAIR: I would like to thank you for the work that you do. I know your organisation and it is a great organisation. We want to thank you for the work you have done during the pandemic. It has obviously been a very difficult time for all health workers. We could continue questioning you for hours, but we have other people to talk to. We appreciate what you have said and it will certainly inform our report and recommendations going forward. Thank you.

Ms Marshall: Thank you. We are very easy to contact if you have more questions.

PANE, Ms Sara, Senior Practitioner, Sexual Assault Program, Zig Zag Young Women's Resource Centre Inc; Member, Queensland Sexual Assault Network

CHAIR: Welcome. Zig Zag is still in the electorate of Greenslopes and it is a fantastic organisation. I invite you to make a brief opening statement and then we will ask you some questions.

Ms Pane: I am here by myself today. Unfortunately, Karin could not be here. She was going to address the general parts of the submission. I want to speak to recommendations 4 and 5 of QSAN's submission. Basically, Zig Zag is a service that works with young women who have experienced sexual violence. Last year we saw about 429 young women aged between 12 and 25 who had experienced sexual violence. I listened to the eating disorders people, and I can say that we have had at least an 80 per cent increase in referrals since COVID began. We are noticing particular issues for young women accessing the mental health sector which have probably got worse during that period. I wanted to speak to those situations today.

Recommendations 4 and 5 are about collaborative partnerships between the mental health and sexual violence sectors. As you would probably be aware, young women who have experienced sexual violence often have experiences of mental health issues and mental illness. Sometimes those conditions are caused or exacerbated through their experiences of sexual violence and sometimes they are pre-existing conditions. A lot of the presentations we see are very complex. Not only are young women experiencing the impacts of sexual violence, which are very broad, but they are also dealing with mental illness and mental health issues.

Zig Zag is a very small service. We have five full-time and part-time permanent workers in the sexual assault team. We get quite a few referrals from the mental health system. For survivors of sexual violence—whether they are minors trying to access adolescent mental health services or places like headspace and child and youth mental health services, or they are in the adult system—there are three main issues going on. The first is the frequency of cycling back and forth through emergency departments, presenting with suicidality and maybe having a short stay and being sent back out into the world with very few pathways for ongoing mental health care.

The second thing we are seeing on presentation to particularly the youth mental health sector is that an assessment is done, which is generally maybe a session, and then they are referred straight back to Zig Zag. Often those referrals are really complex and our work is quite specific around sexual assault. It is about sexual assault counselling around adverse impacts, which could be anything from social isolation to self-blame to trust to boundary issues. We do a lot of work in the area of supporting young women to navigate the criminal justice system, which is incredibly difficult and challenging. We do other things with young women. We provide group work and we do education in the community around awareness raising for sexual violence, so we have a very broad range of tasks in our jobs.

One of the most important things for recovery from sexual violence is stabilisation, and that includes mental health stabilisation. If young women are being referred directly from CYMHS with very severe mental health presentation or clinical presentations, which we do not work with, it leaves us in a very difficult position to be able to do the best work we can with them and to keep them safe and for them to be able to keep themselves safe.

The third area which is difficult is a lack of collaboration. I have had many conversations with mental health services around working together. I can remember one really good case study where Eating Disorders Queensland and Zig Zag worked together to support a young woman. I referred the young woman. Assessment by EDQ was basically spelling out to us what they needed to do and then us working out how we could support without creating a therapeutic overwhelm or having conflicting therapies happening at once. We were able to support that young woman in other areas of her journey through recovery and also encourage her to stay connected with EDQ, because she had a very tortured relationship with other mental health services and was likely to disengage. That is an example of real working together and not just giving them to us as soon as you get a sexual violence related referral in a mental health service. It is better for us to be able to work collaboratively and the outcomes for young women are much better.

CHAIR: I am trying to understand the number of women who are sexually assaulted and who then develop mental health problems. Is it quite common? Are the statistics quite high?

Ms Pane: Very. We see a lot of presentations of post-traumatic symptoms, some of which then dissipate, but there is a percentage of those young women who have PTSD who are clinical. There is a lot of depression, anxiety and eating disorders, and then recovery is impacted for young women who are neurodiverse, who have ADHD or autism. It makes things complicated.

CHAIR: Depending on the physical impacts of the assault, they will presumably have some contact with the police and the health system. Are mental health services automatically triggered for people who have been assaulted?

Ms Pane: No. The QPS has a referral pathway straight to the sexual assault sector. Depending on where the young woman lives, she is referred to Zig Zag, the Brisbane Rape and Incest Survivors Support Centre or wherever in Queensland. As far as I know, there is no direct referral.

CHAIR: Queensland Health has a sexual assault service based at the Royal Brisbane; is that right?

Ms Pane: Yes, the SART.

CHAIR: Is that still only half a dozen people?

Ms Pane: I think it is pretty small and they are dealing with the pointy end—forensics and then a little bit of counselling. Again, they are social workers like us; they are not clinicians in mental health like psychiatrists or psychologists generally.

CHAIR: There are women who are sexually assaulted and that causes mental health issues. Are there also women who have mental health issues who are more vulnerable to being sexually assaulted because of their mental illness?

Ms Pane: Absolutely.

Ms CAMM: I have a follow-on question from that. To your knowledge, when a woman or a man or anyone is sexually assaulted presents to Queensland Health, as part of that response is it true that there is no mental health assessment undertaken at all?

Ms Pane: Not that I am aware of, but I think that would be better directed to SART. I have sat in with young women going through that process and I have not noticed that line of questioning.

Ms KING: Thank you for what you do and the support you provide to so many people at an incredibly vulnerable moment in their lives. I want to ask about mental health assessment at the time of presentation. What do we know about the mental health coincidence with sexual assault? Do people who are assaulted for the very first time necessarily screen up for a mental health disorder at that moment, or is it something that might emerge later?

Ms Pane: Usually, but not always; PTSD in particular will come up and go down. Some young women experience years of sexual assault in childhood and then they go into their adulthood and have a complete mental health breakdown. It can be either/or. For example, I was talking to a young woman the other day who was talking about abuse. Probably about a month after the abuse stopped for her she had a serious depressive episode where she was housebound for a month and attempted suicide, and that is how she came to be referred to Zig Zag. Sometimes there is a prolonged period of time where there are seemingly no mental health impacts and other times it is a quicker turnaround.

Mr MOLHOEK: Could you comment on the need for gender segregation in psychiatric wards and facilities?

Ms Pane: Karin was going to speak more to that. I know that the sector has been concerned for some time around vulnerable women going into psychiatric units. Adolescent units in Brisbane that I have visited are unisex or all-sexes, and it is the same for adults as well. There are definitely concerns around that for vulnerable women, especially if they have a trauma history. Unfortunately, if you are looking at gender violence, we know that it is more likely for men to be perpetrators and that might pose risks for women going into those wards.

Mr MOLHOEK: In the submission there are some statistics that one in five women have been sexually assaulted or threatened since the age of 15. I have heard similar statistics through Bravehearts and other organisations. What proportion of people who have experienced a sexual assault—whether it be once or repeatedly—go on to need mental health support?

Ms Pane: I wish I could answer that. Maybe I need to do a PhD on that one.

Mr MOLHOEK: Is there any data on that?

Ms Pane: There must be, but I am not aware of it, I am afraid, off the top of my head. I have worked in the sector for 20 years and I would say that, for example, a very high proportion of women and young women I have worked with experience suicidality, like chronic suicidality, self-harm issues, eating disorders particularly and PTSD symptoms, but I cannot give you a number. I am sorry about that.

Mr MOLHOEK: Would it be fair to say that when the people you work with come to you they are usually acute or chronic or they have other symptoms or concerns?

Ms Pane: No, the referral pathway predominantly for us is through Queensland Police. If anyone reports to police between the ages of 12 to 25 within our catchment, we are directly approached to take that person on because we know that the sooner support and intervention around this area is offered the less likely they will develop post-traumatic stress disorder and other mental health issues. They go straight through to us. There might be some who have minimal mental health presentations and it is more around just dealing with the criminal justice system, but a high number present with PTSD-like symptoms and other developing mental health issues.

CHAIR: You talked about the importance of stabilisation. Would a significant proportion of the women you work with be affected by domestic violence? Would the sexual assaults be perpetrated by intimate partners and would that then have effects on their housing stability?

Ms Pane: Because we are working with the younger cohort there is often domestic violence in the family. Sometimes it is an intimate partner, but I am going to use the word incest. When they have experienced that there is always that risk of being homeless because they leave their homes and, because they are older teenagers, they are less likely to have child protection put them into a system of some kind. Yes, homelessness is an issue and we do do work around that. Obviously we have a homelessness program in our service to support that.

CHAIR: If a young teenager is the victim of incest and becomes homeless as a result of that, what are the options?

Ms Pane: I think there are various options—not as many as I would like. I have heard of people going into residential care and there are some more informal situations with other organisations. It is a bit ad hoc for that older adolescent group. Technically they could go to Zig Zag if they are 16 or over so sometimes, if we have a vacancy, we end up housing those young women as well. Some of those young women have children so they are prioritised.

Dr ROWAN: In Queensland, there is a task force or a review being led by former Court of Appeal president, Justice Margaret McMurdo, that is looking into forensic services. From your experience working in this area, as far as delays go, how have we got to this point? Is it to do with resourcing over the years? It is obviously a very complex problem. Is there any feedback that you can give to the committee?

Ms Pane: I think both the mental health and sexual violence sectors probably are underresourced. We are definitely underresourced. We have not had a substantive increase in our funding for 26 years. In two years we have had more than an 80 per cent increase in young women accessing with much more complex needs—so definitely money. As far as the task force is concerned, I think there needs to be some legal reform around how victims manage the criminal justice system. There are probably at least two areas that need a lot of work.

Dr ROWAN: Is there an increase in prevalence?

Ms Pane: Of sexual violence? Absolutely. When I started this job 20 years ago, we did not have smart phones. I think there is definitely an increase particularly for younger people. I think a lot of that is instigated through—I do not mean to sound like an old fuddy-duddy; I have teenager—the internet and smart phones and the accessibility that perpetrators have to children and young people. They can reach them anywhere now, and I think that has a big impact.

Ms KING: Are you talking about a kind of grooming situation or they are able to just go in and prey on people and set up times to meet and abuse?

Ms Pane: Yes, to the extent of trafficking. We have had young women who, as minors, have been groomed online and then basically pulled into a trafficking situation where they are living with the perpetrator and basically are pimped out all over the country. That is all online access. It is a pretty dire situation.

Dr ROWAN: I want to add to the question of the member for Pumicestone, which is what I was trying to get to. Without pre-empting the findings of the task force that has been set up to look into forensic services, with all of the associated services dealing with the prevalence of sexual assault, it sounds like what they are having to deal with in managing certain parts of that—whether it is the criminal justice aspects, mental health support and all those sorts of things—have not kept up with the prevalence that has increased over that period; would that be a fair comment?

Ms Pane: I think that is a fair thing to say, yes.

CHAIR: Is the prevalence increase somewhat related to a greater willingness or capacity to report crimes?

Ms Pane: I am not sure. We have quite a high proportion of young women who come to us who have not. I do not know if there has been that much improvement with reporting in Queensland around this stuff. I think there are still a lot of barriers to it. I would say we are noticing increases in referrals that are coming from all over the place as well as Queensland Police: so self-referrals, mental health referrals, schools and family.

Ms KING: Does that mean that there has been an increase in preparedness to self-identify and disclose to somebody, even if that is not making a political statement?

Ms Pane: Actually, yes. I think particularly since there has been a lot of media around and we have people like Grace Tame, yes, young women have been more verbal about it; you are right. Thanks for prompting that. I think that is true.

CHAIR: And the mandatory reporting stuff for teachers and nurses, childcare workers—all those groups that we seem to add—may prompt a bit of reporting as well, hopefully?

Ms Pane: Probably not as much as you would expect. I have seen a slight increase, but then maybe also not as much as I would have expected, to be honest.

CHAIR: That is interesting. Most professional people that I work with would, I would think, report that from an ethical and moral obligation. The law prompts it and probably forces you to think more deeply about some of that marginal and lineball stuff. That is probably a good thing. It is interesting that it has not necessarily had the outcomes we were expecting.

Ms Pane: I think maybe part of that is that there is a level of clamming up going on and people are scared about that. I have certainly worked in jurisdictions across the country where mandatory reporting has been a system that has been entrenched for a lot longer and you do tend to see certain communities being basically quite afraid and not coming forth with stuff. That could be an impact; I do not know.

CHAIR: We talk about the perpetrators of sexual violence and sexual assault. I know it is probably grossly generalising here, but to what extent are we looking at people of a similar age sexually assaulting one another and to what extent do we think that perhaps those people who are perpetrating the sexual assault are also dealing with mental health issues?

Ms Pane: To the first question, definitely sexual violence between peers is a really prevalent thing that we see a lot of. Again, it is often influenced through access to pornography and learning about sex through watching really violent pornography. That is a real issue and it is a growing issue. Yes, I think perpetrators could have mental health issues, but I think a lot of perpetrators do not necessarily have a clinical mental health issue that would be causing them to do what they do. I do not work in that area. I work with the victim survivors.

Ms KING: Certainly when you look at the work of Chanel Contos, for example—I seek your comment; I am not just making a statement—it seemed to me that nothing about most of those disclosures indicated an underlying clinical issue so much as opportunity, alcohol and a sense of entitlement. I would love to hear your thoughts.

Ms Pane: A sense of entitlement definitely, and usually entrenched views on women and children as something they own—entitlement to sex, partners being responsible to meet those needs, yes. Generally I would not say that most perpetrators I hear about have a psychotic illness that causes them to do what they do. That would be a very small minority, I guess.

CHAIR: Coming back to the victims of sexual assault, if they do have mental health issues that are triggered, are they able to be managed in a community based setting by either a GP or some sort of community organisation?

Ms Pane: No, and I think that is where we need mental health systems because a lot of the time the issues they are dealing with are a really acute mental health episode where they are going to kill themselves. That is really frequent. They need to have that crisis support that they can call, like CYMHS. It is a service that knows them and says, 'We have done this plan. Is it working?' I think that sexual assault services can play their role and we certainly play our role in trying to refer and find options around mental health where we are recognising that we cannot contain what is happening. But, yes, I think that we need the big systems to be able to provide that crisis 24-hour response for our young women.

CHAIR: That is not the case at the present time?

Ms Pane: It is with some. Actually with the private system I have seen, if you can pay then you can get quite a lot of support. There are some young women who, probably a few years ago, were accessing adolescent mental health and were getting quite good support that continued even when we stepped in to do our work, and that was really useful. But more recently I think that there may have been a tightening of criteria because of demand from the big mental health systems. It has created this gap where the survivors are not for headspace and they are not enough to be CYMHS and there is nowhere else.

CHAIR: The missing middle that we keep hearing about.

Ms Pane: The missing middle, yes. It is a real thing.

CHAIR: But from another angle now. I want to thank you for presenting today. I want to thank you for all the good work you do in the community. I have seen it firsthand myself. Please take our thanks back to all the members of QSAN. We do appreciate the submission and we appreciate you taking the time to come and present here today. It certainly will help us to form our report and our recommendations.

Ms Pane: Thank you very much for your time.

CARSON, Mr Adrian, Chief Executive Officer, Institute for Urban Indigenous Health

NELSON, Dr Carmel, Clinical Director, Institute for Urban Indigenous Health

SERGHI, Ms Marianna, Strategic Policy Adviser, Institute for Urban Indigenous Health

CHAIR: I welcome representatives from the Institute for Urban Indigenous Health: Mr Adrian Carson, Chief Executive Officer; Dr Carmel Nelson, Clinical Director; and Ms Marianna Serghi, Strategic Policy Adviser. We are running a little bit behind time. Do you mind if we go straight to questions, unless there is information that you particularly want to impart to us? We have read your submission and it was very good.

Mr Carson: We are right to go.

CHAIR: In terms of your submission, in your first recommendation you talked about having specialised mental health and addiction services for Aboriginal and Torres Strait Islander people in SEQ that cater to that 'missing middle'. Can you step us through what that might look like—what the service might be, where it might be based and how it might be rolled out?

Dr Nelson: There are multiple parts to it. As you would have read in the submission, when we are thinking about South-East Queensland it is about working off a platform of comprehensive primary healthcare services—a big network of clinics with a whole range of GPs, nurses and others. On that we build a few layers.

One really important one is the linkage connector service. We have a range of services with skilled primarily Aboriginal people whose role is to provide that intensive transition support. An example of that might be, as people are transitioning back out after having had an acute inpatient admission, that intensive walking alongside at the elbow. That is a critical part of building trust with assertive support and then making sure that they are linked back into the services they need when they are out.

There are usually a multitude of things. That function is really to make sure that people are connected not only to the specialist clinical mental health services but also that their other needs are met that enable them to effectively engage in those services—whether that is housing, legal advocacy and a whole range of other things. In addition, we have a network of clinicians. We employ psychiatrists, addiction medicine specialists, psychologists, social workers, caseworkers and social health support workers. They constitute part of that response that is meeting the 'missing middle'.

In terms of where we would really like to be able to take that, there are two things. One of those is that the funding and the resourcing that supports that is pretty patchy. Some of it is self-funded. An amount relies on Medicare—rightly. In addition, those patchy grants are uncertain so it is about being able to tap into other sources of funding. As we highlighted in our submission, the opportunities are often not really tailored to the services that we are trying to provide. You are trying to massage a funding application or applying for a mainstream bucket and having to take on delivery of services for non-Aboriginal people as well in order to be able to do what you are wanting to do—which is address a specific need and that is the reason that the institute exists. That is the short version.

They are all components, particularly the assertive in-reach and outreach—the bit that provides the bridge between the tertiary, the admitted, the acute and the step back, as well the link into all of those things that help to cement the path for people to end up on a much more stable trajectory and to be able to take advantage of specialised services, as well as building the specialist services ourselves.

We absolutely see that there is a role for sectors other than just ours. We do not see that we need to do everything. We certainly do not want to be providing inpatient care or a number of services that the state has expertise in and responsibility for, but we see that there is a real gap in terms of the linkage between the sectors. We have a critical role to play in addressing those things on the journey for clients who need to transition across sectors. Also, there is room to shift that line of thinking around what sits with the state and what might better sit with the community with community controlled health services.

CHAIR: I wanted to get to that point. That came through pretty strongly in your submission. If we look at planning and funding of services, I imagine that for urban Indigenous health services like yourselves or even the one we were talking to in Hervey Bay, it is a different scenario around planning of services to, say, planning for a discrete community like Cherbourg or Palm Island. There seems to be a strong sense coming through that you think the planning and the funding should sit with community controlled health services. What is happening at the moment? What are we moving from? We can see what you want to move to. What is the present situation?

Dr Nelson: Where do I start?

Mr Carson: 'Very patchy' I think is the term.

Dr Nelson: Yes. The services are really fragmented. I think that is the thing.

Mr Carson: In terms of planning, part of the reason why the institute was established by community controlled health services over 10 years ago was to recognise that there was not planning for this place—this place that is home to well over a third of the state's total Indigenous population and now well over 11 per cent of the country's Indigenous population. There was no plan. Despite commitments around Closing the Gap, there was no plan for—

CHAIR: By 'this place' you are referring to South-East Queensland?

Mr Carson: South-East Queensland. There was no entity. You had various parts of the health system doing their own plans within their respective spaces—whether it be an HHS or a PHN or a Medicare local before that. Looking at South-East Queensland as a whole, the concept of a network system, which is also talked about as a really important agenda for Queensland Health, is something that we initiated over 11 years ago. We looked at South-East Queensland as a place and home to a very significant Indigenous population and how those communities access important services—mental health being one.

We established IUIH to take on the role of coordinating planning and service development in response to needs within our communities. What we have done over that 11-year period is testament to the fact that mainstream planning does not recognise and does not pick up and does not enable. Even if it identifies gaps, there is definitely no immediate move to respond to identified needs and to rapidly accelerate services to address those needs.

As to where we are going now in South-East Queensland, at least you do have an IUIH, which again works across the system with HHSs and PHNs. You have planning in relation to mental health. You have PHNs that have done their own bits across their footprints. It is the same with the HHSs. In our submission we have talked about the fact that for the first time in the country you have a community controlled organisation working with the Queensland health system and PHNs to apply the National Mental Health Service Planning Framework and the Indigenous adjustment to South-East Queensland's Indigenous population to look at what the gaps are based on planning frameworks that are applied by the mainstream health system. That is, again, an important piece of work. The findings will be available by the end of this year. I think there is a time frame for that.

Where are we moving to? We are already addressing the fact that there are major gaps in relation to planning and coordinating responses to what is identified through those plans, but it is a community controlled led solution. In the absence of community controlled led solutions, we end up with a default which is that everyone plans for their own facilities, their own respective footprints. Our people constitute a minority in South-East Queensland and the plans are never about identifying or addressing the needs of our families and our people. It is that challenge in discrete communities where I think the planning is as dire as the need is in those communities too. Everything appears, because they are Indigenous communities; it is necessarily focused on meeting the needs of that population. But in South-East Queensland you do not have a proper planning process that is specifically designed to meet the needs of our population; hence, this is what you see in other aspects of the submission in terms of access to those services.

CHAIR: When it comes to non-mental health issues for the people that you service, are the planning processes better? I know that a fair bit of work has been done in the area of diabetes and that sort of thing. Are there models there that we could roll across to work in the mental health space? Or is it patchy there too and I have an optimistic view of the world?

Mr Carson: It is good to be optimistic, especially in these times.

Dr Nelson: They say that what happens in the mental health space is really just a big amplification of some aspects of fragmentation in the system more broadly. It is about meeting the needs of people who probably have more complex mental health issues. There is a need for people to navigate across a whole enormous big suite of sectors and services and so they are more likely to fall between the gaps. It is not that there is something else that is magnificent and that this is terrible, but that probably there are cracks in the healthcare system generally. When it comes to the needs of people who have mental health issues, those are really amplified. That may be the best way to describe it.

Ms Serghi: In relation to funding, historically for the mental health sector when working with the NGO sector—when funders fund the NGO sector—there is a strong preference to continue funding those with which they have had a long-standing funding relationship. That has not been the community controlled sector. There is also amongst mental health service funders and system leaders a misunderstanding of the role of community controlled health services. They continue to believe that really the only role we play in the mental health service system is psychosocial support provision. In South-East Queensland and in the context of the Institute for Urban Indigenous Health, that just is not correct. We are providing a whole range of clinical support services to Aboriginal and Torres Strait Islander people in this region and have a strong role to play within the mental health service system. But because we do not have that historical relationship, it is really hard to change those usual ways of doing business.

Dr ROWAN: To IUIH, thank you for all the clinical work that you do. As per my register of interests, I acknowledge that I provide some clinical support to IUIH clinics. It is terrific to see the collaborative model of care that you have been able to provide, not only to close the gap but also to support primary care and other services. Mr Carson, you talked about the planning aspects. With the engagement with planning across various hospital and health services, primary health networks and Queensland Health and given the extensive wealth of knowledge and expertise that you have gleaned over time, not only in relation to prevalence of conditions and the populations that you are servicing in various place, what can be further done with respect particularly to mental health? Is there greater engagement in that governance framework when it comes to planning to ensure that all that information is captured from an organisation like the Institute of Urban Indigenous Health and engaged into that planning in a coordinated way for the benefit not only of your clients but also clients who are accessing other services?

Mr Carson: A good opportunity has been created through the health equity reforms that you might have heard about. We have definitely used that—and we have leveraged that—to get the governance connected at a system level. Rather than dealing with the four HHSs, Children's Health Queensland, the Mater and the four PHNs individually, we got them to agree that what we need to achieve health equity is actually a network system approach, which means we all need to come together. We are in the process of doing that. We have created a governance committee with very senior people, the CEOs and chairs, of those respective organisations. IUIH has led out the secretariat for that. There is a commitment to that. We are about to finalise the big regional strategy for how health equity will be realised over 10 years in South-East Queensland. Mental health is a priority under that. Building on what we have done individually with various PHNs and funders and being able to then get a proper systems approach are fundamental to getting the change that is necessary to drive the kind of reforms that, no doubt, this committee is concerned about, because you need to be able to move away from, again, individual service plans to a plan for the system as a whole.

At the moment we are talking just about mental health and mental health services, but when you talk about IUIH you are talking about the whole life course and the whole continuum of needs of our communities—from conception, mums and bubs care, all the way through to looking after our elders, palliative care and everything that sits in between. It is having that broader planning framework that takes in that context. It is very hard for government to be able to connect to it. It has been 11 years of trying to get the system to think about that. It is hard enough just trying to get Health to connect the various body parts into a coherent plan, but this is definitely what we are aiming to do now. In fact, that is a live opportunity. We are meeting next week and we will take the regional strategy to that governance group to consider. If they agree to that, there is a whole lot of collective planning that needs to happen in the mental health space.

I mentioned before—it is in our submission—the fact that we have worked with the Queensland Centre for Mental Health Research to roll out the Indigenous adjustment to the mental health planning framework. We have also undertaken with the Queensland Centre for Mental Health Research—also in the submission—the urban survey that looks at prevalence. There has been no real work done in terms of the prevalence, the needs and the burden of mental health disorders in their various forms in Indigenous populations, in urban areas in particular. Having that prevalence study conducted through the survey and the planning framework means that, by the end of this year, we will have all of that data coming together. We then will be able to connect it up with the broader network system and a governance model with HHSs and PHNs.

The hope is that then we will be able to realise that there are gaps that need to be addressed and they can be addressed, not just through additional funds—although in mental health that is clearly a need—but also through reforming the way services are provided, how they are configured and, really importantly for our mob, who provides them. That is a fundamental thing, too. Marianna referred to this: in urban areas we just think we are going to apply a one-size-fits-all approach to urban Indigenous communities, yet in other parts of the state, such as Cherbourg which you mentioned, there is a very specific plan. We do not recognise the fact that that same kind of specificity is required here. Again, best placed to lead that piece of work is the communities themselves. Again, through IUIH, we have a really unique opportunity—the system has—to be able to do that important work.

CHAIR: Just for clarity, who are you meeting with next week?

Mr Carson: We have the CEOs and the chairs of the four hospital and health services, Children's Health Queensland and the Mater, along with the four PHNs and the community controlled sector—our four members in IUIH. We have been meeting now for about six months doing very tough work—in the middle of dealing with pandemics, floods and everything else—to make sure that we are realising that opportunity and holding the system to account for the promise of delivering health equity by 2031. We have all these things in place. The meeting next week is the leaders of the system in South-East Queensland.

CHAIR: It sounds like an important meeting. The committee would appreciate being kept up to date with any outcomes of that.

Mr Carson: We would be pleased to.

Mr O'ROURKE: Thank you for being here this afternoon and for your submission. In your submission you talk about the NDIS engagement strategy and, in particular, the pilot of the national significance program. I am also thinking about regional Queensland where people are falling through the cracks and are not able to access NDIS services. Could you speak to that?

Mr Carson: It is a pilot that was conducted a couple of years ago now, recognising the fact that Aboriginal and Torres Strait Islander people were not accessing the scheme anywhere near need. There was a recognition from the agency itself that the system was very complex and navigation of the system was almost impossible, particularly for those who are what they call 'beyond the line of sight', that is, those who were not in receipt of state funded disability services at the time the scheme was established. The vast majority of our people were not actually in receipt of state funded services and therefore were invisible to the agency. They had funded local area coordinators to undertake that work with communities; the problem was that no-one thought to apply a Close the Gap target. In terms of that really important social policy reform, one of the biggest they claimed since Medicare, there was no closing of targets. Therefore, there was no requirement for anyone to be particularly concerned about how our people accessed that scheme.

After a fair bit of work, we made an arrangement with the NDIA where they allowed us to work with our communities, with the consent of our families and clients. We became their agents. We did a lot of work to ensure that our part of the system could undertake the necessary assessments for the NDIS—access request forms—making sure that we were better able to do that, given we saw some pretty low hit rates in terms of Aboriginal people's attempts to access the scheme. It was about making sure that our clinics knew how to do that. Also, having access to data inside the NDIA meant that, as we were starting to put people into system, we could track where they were. To the extent that the clients actually prescribed us as the agent, instead of the NDIA ringing up on funny numbers, private numbers, and our people not taking the call or even necessarily understanding what they were talking about, they could work through us so we would be there at the side or at the elbow of our clients as they accessed that scheme.

From access request and assessment from the planners in formulating the plan, in terms of entry into that scheme through our pathway—we called it a pathway; the NDIS pathway for South-East Queensland—we saw access rates increase to well over 85 per cent. That was the hit rate for people coming in. We were connecting that with community engagement. There was a point in time in Cairns, if anyone here is from Far North Queensland, there was some work done by the NDIA. When Aboriginal people were asked what they thought the NDIA scheme was, particularly the agency, they thought it was the NBN. That was how good their engagement had been in such a massive big policy reform with huge amounts of money, huge opportunities and great needs. With all the money that everyone blew on Indigenous engagement, no-one knew what the NDIA or the NDIS were or what constituted disability for the purpose of that.

Through community engagement and working with our communities, supporting them all the way through, meant that we could see people accessing the scheme. We could see where they were in the process. We could hold the NDIA to account. Then you had some turnover within the agency and some fairly senior people in the organisation left, and there was a combination of loss of corporate memory and maybe people looking at the expense of getting these outcomes. People opted instead for a dedicated pathway in South-East Queensland. The whole idea was that that pilot would then inform what would happen across the country. The agency chose instead to shut it down and opt for a community connector program in partnership with our national body, NACCHO, which then threw bits of money across the country. It was well intended to promote the NDIA and the NDIS to our communities, but did not provide the access into the scheme that then enabled our mob to receive the benefits.

We are now seeing some data coming out of the agency that talks about the fact that there are many millions of dollars worth of packages that Aboriginal people have been able to secure, but because people are not able to provide the advocacy, support and whatnot large amounts of that are not being utilised. Packages are sitting there with many millions not being accessed. That is the issue and it is not the first time. It is ironic that we now have aged-care reform. They have recognised that accessing the aged-care system for elders is almost impossible. It is very complex with My Aged Care and all the portals and everything else. What has come out of the aged-care royal commission, and it has been funded now in the budget, is they are now talking about an Indigenous pathway for aged care. Hopefully we will see that then applied to the NDIS and NDIA. Unfortunately, it did not. For your constituents in Central Queensland, no doubt there are huge needs. It is something they were also promising in South-East Queensland, but it did not get the support it needed to then extend and support other communities to see the benefit of that. It was a really important measure.

CHAIR: Thank you for that. I think you need a PhD in something to navigate the My Aged Care system, having tried it a few times! You mentioned the continuum of care from birth through to palliative care. In terms of the social determinants of mental health issues, if more funding were available does IUIH have the capacity to operate in the perinatal, mental health and early parenting space, and in housing stabilisation?

Dr Nelson: We are definitely operating in the perinatal space. For example, we have a world-class birthing program called Birthing in our Community. It is a really comprehensive model that includes continuity of midwifery carer through birthing. Equally, if not more important, it is a suite of wraparound services that help to address a number of issues, particularly determinants of health in the early stage of pregnancy and early parenting. That particular program had a great *Lancet* publication essentially showing a closing in the gap in preterm birth rates. That is a pretty important indicator, behind that were improvements in just about every perinatal outcome you can think of. There is some as yet unpublished but really important data around family cohesion, parenting and I guess that early trajectory of kids that really sets them up for a good life beyond. Definitely in the birthing space we see that as absolutely fundamental. It is the beginning of everything, isn’t it? If you get that bit right, you potentially change generations.

The other thing to mention in the determinant space is that IUIH is also a community legal centre. It was self-funded. We employ a couple of lawyers. We did that because we see the health-justice link as being absolutely critical and instrumental, particularly when thinking about the mental health space. We have had some really spectacular stories of people who have had the expression of mental illness as a consequence of hopelessness, actually. When you can plug in the power of the law on the right side behind people to advocate for equity, housing access, being able to remain in housing, being able to have that kind of advocacy behind you when the law might be pressing up against you in the wrong way, and at the same time coupled with the services that can help make sure you are less likely to be bumping into the law, it is incredibly powerful. We have seen really great stories of people who have been able to ditch the antidepressants simply because I think hope has been restored when that level of advocacy kicked in.

If I thought about the kinds of resources in terms of addressing some of those determinants that would really make a massive difference, we would love to grow our two-lawyer, self-funded health-justice partnership to be a much bigger entity. It is not in competition with other varieties of legal service. The thing that is unique about it is that those providers are there at the beginning of health and at the beginning of the perinatal journey, they are there with women and families at the preventive, educative early-intervention end—that is a really critical determinant—and many others as well.

CHAIR: In fact, it is interesting that the World Wellness Group, a multicultural refugee health service, is coming in this afternoon and they have done the exact same thing around health justice. I thank you for presenting today. It has really been very useful. It will certainly inform our recommendations and report going forward. Please thank all of the people who work or volunteer for your organisation for their work during the pandemic. It has obviously been a tough couple of years. Thank you very much for coming in.

Proceedings suspended from 1.34 pm to 2.02 pm.

ALEXANDER, Ms Matilda, Steering Committee Member, Rainbow Families Queensland

DAWSON, Mr Benjamin, Communities and Partnerships Liaison Officer, Queensland Council for LGBTI Health (via videoconference)

KANAPI, Mr Trevor, Steering Committee Member, Rainbow Families Queensland

REYNOLDS, Ms Rebecca, Chief Executive Officer, Queensland Council for LGBTI Health (via videoconference)

CHAIR: I ask you to make a very brief opening statement, and then we will go to some questions from the committee.

Mr Kanapi: Jingeri yura, everyone. Firstly I acknowledge the traditional custodians of the lands that we gather on and pay respects to elders past, present and emerging. Thank you for the opportunity to talk to our submission. I am representing rainbow families across Queensland. Rainbow Families Queensland supports, celebrates and advocates on behalf of LGBTIQ+ parents, carers and their children right across Queensland, including regional areas. Our vision is to create a Queensland that meets the diverse needs of all rainbow families with a strong commitment to social inclusion, mental health and wellbeing, suicide prevention and ensuring all rainbow families and children are healthy, resilient and connected to community.

Some of the work that we are involved in is running a range of social groups, events and a range of parenting information sessions, whether that is fertility, fostering or the many different journeys that parents can take, and advocating on law reforms. We have also created a variety of resources promoting inclusive childcare and health services and providing that major ill and mental health across the community. I will hand over to Matilda.

Ms Alexander: For years our community and our families have been in a closet not of our own volition but due to the silence of government, workplaces and society. When we were seen it was as objects of tragedy, pity or deviance. Our data was not collected. Our voices were not heard. Our issues and needs were not studied academically. Our solutions were found in our own communities, where volunteering and community based care made up for the silence outside this involuntary closet. We see this playing out today in the reluctance of the LGBTI community to access mainstream services and mainstream groups in the same way that they come to us looking for support, looking for solutions and looking for better mental health solutions.

Rainbow Families Queensland has seen issues through our groups that are very pertinent to mental health and to the current day and age. We see housing issues, especially emerging post flood. We see domestic violence issues, especially in relation to COVID lockdowns—and not just domestic violence in the traditional sense that you would think of it but families that are very unsafe places for their children to be in—and a wide variety of domestic violence that is unique and particular to our community.

We have seen the devastating impact of the debates around marriage equality and, more recently, around the religious discrimination bill and the consistent feeling of our community that our rights and our equality is up for debate. Whether or not we are a full and equal part of society is a position that we, our families, constantly need to defend and our children need to defend when they are in a school environment. This kind of pressure on the LGBTIQ+ community has a devastating impact on mental health, and the kinds of statistics that you are going to hear today in terms of the mental health outcomes for LGBTI people are a reflection of those challenges.

The key message that Rainbow Families Queensland would like to put to you today is that me and Trevor are here voluntarily. We, together with the other Rainbow Families members, run essentially a statewide support service for rainbow families in Queensland with no ongoing funding. We organise groups which could be called social groups. We have won awards for our work, but essentially they are not social groups. We organise events where legal people come and support services come, where there are stalls and things like that, where people can come and feel safe to talk about their issues and where we can then provide them with the appropriate levels of referral and support.

The idea that this essential community service should continue to be voluntary in a day and age where we are past this involuntary closet—we are out of the closet. You know our data. You know our issues. We are now getting studied. You know the things that are facing us. You can read them in our submission and the Queensland Council for LGBTI Health's submission. You know this.

Do not make us keep doing this on a voluntary basis. It is time to take it seriously. It is time to give funding to organisations like ours that have been doing it voluntarily for decades. I am talking more broadly about volunteering within the LGBTI world. It is time to give training to mental health professionals and to all professionals who are working with our community which, let us face it, is all people in the health sector, and to give funding to build the capacity of mainstream organisations. When we are talking about giving funding, we do not need a little grant here or there. We have produced resources. We have done some great work. We have LGBTI families, Rainbow Families Queensland brochures on child care, on relevant birth parent support and a whole range of other different things. What we need is ongoing and sustainable funding to recognise the work that we are doing.

Ms Reynolds: I appreciate the chance to speak with you further and to have this opportunity to make a significant difference in the mental health outcomes for all Queenslanders. I acknowledge today all of the First Nations people on whose country we live, work and play and today meet, and I pay my respects to the elders of our First Nations communities. I hold in deep esteem those leaders of today who continuously work to translate systems and practices into meaningful and relevant approaches for their families and communities and, importantly, as we make this submission, into opportunities for improvement. Our organisation affirms our undertaking to do so alongside and in partnership with our Aboriginal and Torres Strait Islander communities in Queensland.

My name is Rebecca Reynolds. My pronouns are she and her. I am the CEO of the Queensland Council for LGBTI Health, which has been a home for lesbian, gay, bisexual, trans, intersex, queer, sister girl and brother boy people in communities in Queensland for over 35 years. We are proud to be a community-led and community owned health and wellbeing service which represents the diversity of our communities. I am joined today by my colleague Ben Dawson, who works in facilitating a multitude of communications and partnerships at all levels of community and government.

I often have the privilege of seeing, speaking to and walking alongside many communities across Queensland that have vastly different experiences in accessing support for their mental health, and my role in this space is to work to understand my community's mental wellbeing and how they view and understand it so that we can all be a part of the solution to strengthen the foundations of overall wellbeing.

It is true to say that those friends, family and colleagues that we have living in rural and regional areas, or even just in the outer suburbs of Brisbane, do not have physical and ready access to relevant and appropriate services and supports. Distance is a tyranny, and in the absence of system supplied supports peer-led, locally run groups for the removal of social isolation and loneliness are an essential positive protective factor to minimise suicide in our communities. That is the reality of our work and for our team at QC and for the other organisations working within this sector.

People know that we exist because they have a need for support that they have identified. Our lack of resourcing to be able to see folk in a timely manner or where they live, work and play is something that sits heavily with our team. The demands are taking a toll on our workforces, paid and unpaid, and our communities alike. Waiting times above three months we feel are unacceptable, but greater resourcing is not available to change this. Fortnightly social support groups are essential, but in an unfunded organisation reliant on volunteers to run means that even something like a COVID diagnosis has the impact that events need to be cancelled.

We are in a mental health crisis and we have been for years now. This reality does not go away unaddressed and over time it worsens, deepens and becomes increasingly more complex to solve when financial resources and the trust that timeliness and responsiveness convey are eroded because of an overburdened system.

You have the stats in front of you. I am not going to go through them again here more than to say that there is evidence before you that needs to be acted upon. In our state there has been inquiry after inquiry into loneliness, isolation, discrimination and vilification. We all know there is a problem. Our recommendations and those of our colleagues in other frontline support organisations remain the same: please do something to help us rebuild the resilience and positive mental health of our communities. We know the steps to take to do that, but we actually need your support and partnership to be successful.

A problem of this size cannot be tackled in isolation or by a piecemeal approach. Our communities, as Matilda and Trevor have just said, have a long history of discrimination and systemic oppression. The toll that it takes to remain resilient is a heavy one and it leads to increased isolation and loneliness as folks choose to live their authentic lives. Our communities know and could tell us that there are many contributing factors to poor mental health outcomes, including social isolation from families, friends and connection points all around society.

At worst, it signals that people feel othered and excluded, unwanted and discriminated against and, at best, we are not the norm. This has been made worse by the ongoing commentary around our bodies, relationships and lives in the media and in those institutions that hold power over our lives. If you look at an analysis of the media over the past four weeks, we have had schools, sports and religion at the top of that list—all settings where our existence has been questioned and the meaning of our lives attempted to be eroded. The counterbalance of this is positive visibility and coordination of services and supports.

We need a mechanism that works across government to coordinate the spheres of influence that have a bearing on our community's mental health and wellbeing. There is a siloing of responses across housing, alcohol and drug services, family support services, transport and care worker services, community visiting services, clinical health services and mental health—notwithstanding legal and framework regulatory responses into discrimination, vilification and hate crimes, justice and others. Opportunities to improve the system require coordination and they require embedding within the communities that they are hoping to change and champion into better mental health outcomes—participation, connection, kindness.

As peer-led community based organisations, we are all too familiar with being the people who pull these threads together. When the impact is on us as well, as members of the communities we work to support, the need for funding for our organisations becomes even more pressing and significant, particularly those essential organisations that receive no funding at all but are considered an essential piece of people's health and wellbeing.

Peer-led community based activities like Rainbow Families' support groups, art therapy workshops and community barbecues may seem like too simple a solution to a complex problem, but we know that Queenslanders with low mental wellbeing do not find it easy to look after their mental health. We need to make it easy for our communities to be connected into the supports that will help. We know from talking with our communities that a significant portion of these folk feel that being judged is a barrier to their mental health and wellbeing and that they will not access supports if they feel that there is a barrier or stigma. The need for increased visibility in a variety of settings is key to addressing stigma, both real and perceived.

There are opportunities within the system to better allow for coordination of pathways and support. The system navigator concept utilised within many services, systems and supports is a useful way to frame the expert guidance and support that would make a difference. Defragmenting a system will take time—years, if not decades. Providing expertise in navigation and investing in the workforce that is able to do that at a local level across the state, with relevance and integrity, will be a tool that will be able to withstand systematic change as it occurs.

With peer-led navigators at the heart of the journey, barriers will be lessened in terms of their real or perceived role in accessing mental health services and supports. This will allow for the increased investment of our primary healthcare system and our specialist organisations over time and in a way that lets reform happen meaningfully, without leaving any group behind.

We resiege the recommendations within our submissions and our colleagues' submissions. We welcome your thoughts and feedback on ways in which we can further work on this important and life-saving piece of work together. We know as organisations working in this space that this conversation is everywhere, and it is now. As my colleagues Matilda and Trevor have said, now is the time for investment and growth.

CHAIR: Is Rainbow Families an organisation for parents that are LGBTI, parents of children who are LGBTI or both?

Mr Kanapi: We are an inclusive organisation. We would have representatives from all of those. We were primarily founded around parenting and LGBTIQ+ identifying parents.

CHAIR: What is the relationship of Queensland Council for LGBTI Health with the Queensland AIDS Council? Are you totally separate?

Ms Reynolds: It used to be us—one and the same.

CHAIR: I did a couple of shifts many years ago, when I was first elected, at the health clinic in Newstead. We have heard a lot about the importance of perinatal mental health and the need for early parenting support as a response to dealing with social determinants of health care. How important would these services be in rainbow families?

Ms Alexander: It is one of the areas that needs particular focus. Mainstream services often cannot provide the level of care that we need and the specific knowledge, say, for trans fathers who are giving birth, or for gay male fathers who might be excluded from antenatal classes that are designed for preparing you for after you have a newborn baby.

It is one of those areas where there is a strong point of difference for all of our families and an area that needs reform and specific attention. We get a lot of new parents coming to our events, which I think demonstrates the need that is out there. A lot of them have stories that are quite shocking to hear. We put a case study in our submission: one of the parents who came to a group was told, 'Your baby needs a male role model. Where is the father?' That is quite a common story.

After I gave birth to my first son and I was in the hospital bed, I was asked, 'Which one of you is the man in the relationship?'—between me and my female partner. Literally the first words my child would have heard coming out into the world were, 'He doesn't look like you.' This is particularly the case when there is an intersection with race. Because my children are Aboriginal, I am often asked questions like, 'Who is their father? Where did they get their hair from? Where is their father from?' Of course, I have to come up with appropriate responses to those questions because they are going to be asked those questions all the time in schools. That can be very othering. It can make you feel like your family is something that you need to explain. It is something that does not fit neatly within a box of people's expectations; it constantly puts you on the outer.

CHAIR: Who asked that question, just out of interest? Was it a midwife?

Ms Alexander: It was a chaotic time. I actually do not remember. It was a medical person.

Mr MOLHOEK: The Queensland Council raises a number of concerns in your submission around increasing capacity and strengthening access to acute care. I have probably seen that in just about every submission. I was interested in your comment about removing barriers for access to mental health services. What are some of those barriers?

Mr Dawson: There are many different barriers that contribute to LGBTIQ+ sister girl and brother boy people across Queensland. One of those is the safety of accessing mental health services. You will see it reflected in some of the statistics. One study found that over three-quarters of participants are more likely to use a service that has been accredited as an LGBTIQ+ inclusive service. I believe that this is really important. The evidence shows that the difference between somebody reaching out for help and possibly saving their life is the step of thinking they will be safe if they go to a service.

I was watching some media from 40 years ago. Some MPs were interviewed about some things that were happening decades ago. It is not that long ago that a lot of our communities lived through that. Some references to mental health being the solution were weaponised against us. I think there is a lot of trust to be built there; there is still a long way to go.

Ms Reynolds: I think it is real or perceived stigma and real or perceived cost associated with accessing services and supports. Quite often when there is a waiting list at a specialist service, someone who is looking for support around gender or their body will know that there is a certain number of specialist clinics or practitioners across the state and there are very defined lists of those. If they cannot get in through a particular scheme, through a referral or through a mental health care plan or there is a gap cost, that places it out of the realm of so many of our community members, particularly those living in rural and regional areas. One of the good things that has happened as a result of the COVID pandemic is that so many more services have become available via telehealth. There is still a requirement for people to be seeing a GP or a specialist practitioner once a year to be able to have the rest of the sessions delivered by telehealth. That is still a real barrier in terms of distance and support.

CHAIR: I wanted to ask a question of the Queensland Council for LGBTI Health. The federal Productivity Commission talked about the need for localised planning in the commissioning of services. They suggested a model that would be based around the PHNs and HHSs doing that together. In terms of better access for your community, should that planning involve trying to improve access into existing services or should we be trying to increase the availability of specialised services like yours throughout the state?

Ms Reynolds: It is a catch 22 situation with HHS and PHN regional planning and regional plans. They do a needs assessment in terms of the delivery and the prioritisation of services and, therefore, what they commission. If we do not have a specialist service in the area or someone available to advocate when that needs analysis comes up—a footprint in the area—then the communities are left out of that needs analysis and another cycle goes around of services not being provided that can then get the data to identify the need that can then point to having a specialised service in the area. In terms of all of the different state and federal mechanisms and the different funding across ageing and disability and mental health/suicide prevention to the PHN space and the primary frontline stuff in the HHS space—Aboriginal and Torres Strait Islander health—we need on-the-ground coordination to point everybody to what they need to be looking at in those areas so we do not miss out just by virtue of not being there on that day.

Mrs McMAHON: There are two areas that I want to look at. In terms of the intersection between mental illness and stigma around being a member of the rainbow community, we are talking about almost a double stigma. In terms of not only seeking help but also for those who are choosing not to be open and declare who they are—I think the term was 'living your authentic self'—what kind of mental health impact does that start to have on people as they continue to hide?

Mr Kanapi: Obviously it affects all facets of your mental health and wellbeing. Within Rainbow Families we have a cohort of mature and adult parents who have come out of a heterosexual relationship and have only just found their authentic self. That has a lot of consequences in terms of particularly isolation. Not only are they isolated from their family and their friend group—obviously they knew them in a different capacity and there were expectations around that—there are a lot of issues around access to children and how that is seen, not only by the community but also throughout the systems that are there to support them. The whole process of them finding themselves has multiple impacts on their mental health and wellbeing at the time and ongoing into the future.

Mrs McMAHON: Is there a particular area of counselling that is available for families as they work through the changes they are experiencing?

Mr Kanapi: Yes. Our organisation is one of the key ones to support them through that network—whether it is through social events and gatherings or through online mechanisms. Our focus is around creating that connection and network with others who have that lived experience and can support them through that. It would be great to ensure there is access to counselling and other services through mental health funding.

Ms Alexander: Time and time again we see our families and our community going to mental health professionals or other professionals to seek help and being the ones who are then in the position of expertise having to explain, 'This is what this does to your body. This is why I am feeling like this.' They are going there to receive a service, but what they are realistically doing is providing training. When you are in that position, you do not feel that you can have an open and honest dialogue because you are having to justify your existence.

Mrs McMAHON: That goes to my question. I am really glad to see that even in schools these days our young people are far more open and willing and far more knowledgeable than I am about many of these things. I think I have declared that I am the mother of a non-binary child. I am learning so much every day, week, month and year. Given that our young people are over-represented in mental health issues, I am interested to know what help is out there when they are questioning and they are going through all of these changes, as well as just being teenagers.

Sometimes when I am in town I see lots of little signs saying, 'This is a rainbow friendly service.' These things do not exist in the outer suburbs and in regional Queensland. I do not know, Barry, whether you have seen things like that. They are not out in the suburbs where our kids are. What footprints are out there either through the schools or through headspace? What do we need to have in the suburbs and in the regional areas to help these kids when their GP is more clueless than the 13-year-old? Is there anything out there or what do we need?

Ms Reynolds: I can point you directly to a trial that is being run in Brisbane North PHN, extending as far north as Bribie, Caboolture and as far south as Teneriffe, over the last three years. It was a federally funded program which ceases on 30 June this year. For school-age children, it specifically provided a combination of in-school education at participating schools and wraparound support for students and teachers in partnership with Open Doors Youth Service, which is a frontline social support, counselling, after-care support service which also does drop-in, food, housing assistance and all of those things. For the most part, outside of the city area—in Cairns there is an amazing organisation called YETI, Youth Empowered Towards Independence, that does some spectacular work as part of their same-sex attracted young people support group. The work is being done through headspace where there are staff there who are trained and willing to do it.

A program of training that sits as a mandatory component for government funded services is essential. We have areas like Bundaberg, which had a prom in the last year for young people that was really well attended. They have an event twice a year at the pool in Bundaberg which is for LGBTI young people. We know that when workers within these organisations are funded to be across our state they are well attended and well supported. From there we see school groups grow and other initiatives grow within those communities. Funding for workers to make it a full part of their role, as opposed to an optional 'if they have time and energy', is essential.

Dr ROWAN: Thank you very much to both organisations for the work that you do. I wanted to come to the Queensland Council for LGBTI Health. My question is specifically around accessing mainstream health care. Obviously there is still a lot of stigmatisation in society, as we know, whether it is race or ethnicity or sexuality or gender. In the end, we are all human beings rather than people being defined in a particular way—that stigmatisation. The government has released its GPs in Schools program to enhance health services that are provided in schools. The first question is: what opportunity is there for partnership with that to provide ongoing education in schools around a range of these issues?

The second question is about Health and Wellbeing Queensland and that population health side of things. We are trying to get across Queensland in a partnership way. There are things that the PHNs will do and the HHSs will do. At the end of the day, we want to try to get to a point—I do not want to be naive about it—in society where people are not going to be judged or stigmatised in relation to their sexuality or gender, let alone whether they have a disability. There are lots of issues in our health system around people with disabilities or around race or ethnicity having barriers to access to care.

The two questions are: what can be done in schools with that program in a partnership way and what can be done through Health and Wellbeing Queensland, given that that is an agency within the state government's remit?

Ms Reynolds: I will start with the GPs in Schools program, which is an amazing initiative in terms of meeting people where they are and that response being able to be outside the family home and done in what is supposed to be a safe place for a student. The first thing we need to think about is: is it a safe place for the student? Have they already experienced, coming into that school, a lack of respect for how they present in terms of physicality or the uniform they would like to wear, what bathroom they would like to access or if they would like to be known by different pronouns or a different name? That place of safety in terms of that GP delivering that service successfully is absolutely essential and needs to be done as part of a capacity-building health and wellbeing initiative that wraps around that.

At the heart of that is an onus on the Department of Education in terms of inclusive and respectful practice within the curriculum as well. I commend them for the reviews they have been doing of that over the last 12 months looking at kindergarten to year 12 and different safe school programs that are happening. Those are all essential when we are talking about the coordination of services and supports.

A GP within a school sometimes will have the barrier, depending on the age of the student, of actually needing to speak to the parent to be able to progress in terms of hormones or another pathway that they would like to go down for gender. We know, as people working in this space, that with young people in particular in Queensland they have a lower level of resilience than maybe our older Queenslanders. Our surveys and reporting tell us this as well. In terms of years of experience and having been through a pandemic and floods and fires and everything that young people have been through over the last couple of years, I can understand that they are feeling a little less hopeful about the future.

To be able to access and articulate what support it is they need from a GP without being able to see it in their community around them is still going to create a barrier. I love the idea of it. With appropriate supports wrapped around it that are looking at holistic health and wellbeing, it could be a huge success. It just needs some really specific and careful thought about it to make sure it is safe for our young people.

Dr ROWAN: Health and Wellbeing Queensland was probably the only other bit to that—from a population health perspective.

Ms Reynolds: Health and Wellbeing Queensland in terms of a population perspective probably ties into my answer just then. If I refer to Maslow's hierarchy of needs, does that ring true for everybody in terms of, if you do not have a roof over your head, if you do not have food on your table, these things are way down the line. From a population health perspective, our families are more likely to go back into those places of homelessness, low poverty, incarceration, being out of the system, being in the foster care system. We really need to stabilise that whole-of-community approach to it before we start going into those particular avenues.

Ms Alexander: In relation to our schools, we cannot not mention the importance of strong anti-discrimination laws. We have some parents who were involved in the Citipointe debacle and a number of other different schools around that time. The Queensland laws around discrimination are so strong and good around this particular point. I know there is a review and there are lots of ways that the act could be made better. We need to ensure that those protections remain. In terms of Rainbow Families Queensland, we have also come up with some resources around Mother's Day and Father's Day and the best way for a school or a childcare centre to approach that. They can be very tricky and sensitive days for our communities.

CHAIR: I think both organisations talked about the impacts of having to fight for acceptance of who you are as people. We had a young presenter here from the LGBTI community who challenged the committee and said, 'When you folks were younger, being gay was not talked about.' I said to her, 'When we were younger, being gay was actually illegal and quite highly punishable, as well as all the other social stigma that went around it.' I think back to my earlier years of nursing—and there would be other panel members who might recall this as well—and caring for particularly young men dying of AIDS who were effectively told that they were deserving of what they were going through because of the choices they had made. That is 35 years ago now. That stigma must have a traumatising impact on people which must contribute to greater degrees of mental illness. Is that reasonable to surmise? Could you expand on that a little?

Ms Alexander: Some of those comments are not just historical; they are messages that unfortunately young people are still hearing today. Even as recently as the religious discrimination bill and the debate that that triggers—it opens the floodgates for those prejudicial values to be openly expressed.

Mr Kanapi: I could talk about high school—being spat on when I walked into school, being bullied, being beaten up, being called 'faggot' and 'poofter' across a courtyard and not just to my face—and the impact that has had. I have had some dark times, but I always knew I wanted to be a dad too. One of the most heartbreaking things is when my son's friends at his school are told not to play with him because he has two fathers. That brings back a lot of those mental health and wellbeing issues. When it is your child who is being affected just by you being your authentic self, it is heartbreaking and devastating at times. It is real. As Matilda said, it is still around.

CHAIR: Is there anything to add from the council's perspective?

Ms Reynolds: I can speak to particularly the population group that you just referenced. We have recently been in Far North Queensland running what is called an Aged Care Navigator Trial, which is around encouraging older folk to access government supports and to work out what they are eligible for. There is a really large group of people ageing with HIV in that region who do not want anything to do with a government system or support because of what that meant for them. The triggering nature of the fact that something is branded as a government service is still a barrier—just sheer badging with a government logo.

CHAIR: On behalf of the committee, I would like to thank all of you for your presentation here today and for the time you have taken to make your submissions. We all sincerely thank you for the work that you do in various ways in the community, even if it is just having a barbecue in the park. I am sure it is a very good barbecue that does a lot more than just give people a snag on bread—that is for sure. We really appreciate the work that you do. We also want to acknowledge the work that you and your volunteers and staff have done over the last couple of years during this pandemic. It has been a particularly difficult time for people in our community but particularly health workers. We want to thank you on behalf of the Queensland parliament for that. The submissions and your evidence given here today will contribute to our report and to our recommendations and hopefully to improvements for mental health services for the entire community. Thank you very much.

BLAZEVIC, Ms Gordana, Consultant, Thriving Multicultural Communities, The Migrant Centre Organisation Inc.

CHO, Ms Joyce, Principal Settlement and Community Development Coordinator, Thriving Multicultural Communities, The Migrant Centre Organisation Inc.

KUYANG, Ms Magdalena, Counsellor, Queensland Program of Assistance to Survivors of Torture and Trauma

PADHEE, Ms Jamila, Chief Executive Officer, Queensland Program of Assistance to Survivors of Torture and Trauma

SAKHA, Ms Zainab, Community based trauma recovery practitioner, Queensland Program of Assistance to Survivors of Torture and Trauma

ZUBAC, Ms Zeljana (Anna), Executive Director, Thriving Multicultural Communities, The Migrant Centre Organisation Inc.

CHAIR: Welcome. I would ask each organisation to make a brief opening statement. The briefer you can keep it, the more questions we can ask you.

Ms Padhee: Thank you for the opportunity to present before the committee. The incidence of psychological distress and trauma is much higher among former refugees than people who have not experienced displacement or dispossession. However, for most people refugee trauma does not need an acute mental health response. Instead, trauma recovery requires a compassionate, gentle and patient approach. At QPASTT we strive to provide a culturally safe place where our clients can heal from trauma and reclaim their lives.

Unfortunately, the need for our services has increased greatly to the point that we currently have a waitlist of almost 500 people. We attempt to triage vulnerability to mitigate risk. However, as a CEO, our waitlist worries me greatly due to the level of clinical risk for people waiting for our support, including children. The experience for us is mirrored across the entire mental health system. By that I mean that the level of acuity needed to quickly access support has increased, meaning that people are no longer able to access early support when their symptoms are less and more manageable. We are forced to work at the crisis end of the care continuum, thereby neglecting prevention and early intervention. QPASTT is not challenged by a lack of passion, dedication or competency. Our major challenge is simply one of capacity. I will hand over to my colleague Magdalena.

Ms Kuyang: Thank you for giving me the opportunity to speak here today. My name is Magdalena Kuyang. Since 2006 I have been working with QPASTT as a counsellor in Woolloongabba and Logan, where I support individuals and families. I studied a Bachelor of Human Services, majoring in families and communities. I am originally from South Sudan. I came to Australia in 2004.

The one truth that is present for every parent that I work with is that they want the very best for their children. Many have experienced extreme danger to seek safety. Many have sacrificed their own wellbeing for their children to have some comfort and protection from the effects of persecution. Despite their highest aspiration that their children should not suffer, trauma steals parents. It can dominate and take them away from their families. They may be present in body but their minds are somewhere else. Some parents I support are consumed with worries. Others are numb and find it difficult to feel. Others use substances to block their minds. What trauma steals is good attachment between parents and their children.

There is tremendous love, of course, in parents from a refugee background, but the basics that are needed for attachment become challenged. Being able to attend to a child's emotional needs becomes harder. Trauma also steals family joy. Parents do not allow themselves to play with their children because of guilt. How can they have fun with their children when others are in danger? The burden of trauma then shifts to children because they grow up with the trauma from their parents, affecting the very essence of their most important relationships.

What I wish for the committee to understand is that refugees are resilient and families can thrive. However, help is needed early and not when family circumstances have deteriorated. The best help is a feeling of being culturally safe, and that reduces stigma. Stigma and shame cannot survive compassion and empathy. Having skilled community connectors with refugee lived experiences working in communities to improve understanding about trauma recovery and reduce stigma is the best enabler of prevention and early intervention. Building a refugee lived experience workforce will require dedicated resources, but that is our best chance of healing trauma and stopping the intergenerational cyclical.

Ms Blazevic: I will start by acknowledging the First Nations people on whose land we meet and pay respects to elders past, present and emerging. Thank you so much for this opportunity to share with you some points in addition to the submission that has already been submitted by TMC. My colleagues, Anna Zubac and Joyce Cho, will predominantly answer any questions that you have and I will make the opening statement.

For migrants and refugees, their visa represents the promise of a better life and a brighter future. This has been the promise made to every migrant since voluntary migration started in Australia. With an escalation of mental health issues over the past three years, for 40 per cent of TMC's clients this promise may forever be broken.

The Gold Coast is Australia's sixth largest city, with a population of almost 600,000 people. It is often described as the jewel in the crown of Queensland's tourism industry. However, when it comes to community services the Gold Coast is often regarded as an outer suburb of Brisbane. This often happens when there is an appetite to centralise services. One in every five people living on the Gold Coast was born overseas. TMC services a subset of this population who come from culturally and linguistically diverse backgrounds. They are seeking to access settlement, training and employment opportunities that can be facilitated by TMC. More recently, the profile of people seeking to access these services has changed drastically. Over 40 per cent of people presenting to the TMC have underlying mental health issues, and that changes everything.

TMC is funded to provide specific services: settlement, training and employment, community services and social engagement. During the provision of these services, increasingly it becomes obvious that there are other issues impacting our clients and there are underlying mental health issues. When a client demonstrates these issues, they need to be addressed before any real progress can be made in terms of settlement outcomes such as providing successful training that can lead to securing permanent employment.

TMC plays a critical role in supporting its clients. The focus for TMC from the outset is to understand the clients' needs—all of their needs and not only the ones that they initially present with. Awareness of a client's issues, even if there are multiple issues, including mental health, allows TMC to develop a case management plan. Where possible, this includes leveraging existing mainstream services in collaboration with TMC's value-added services. TMC asks clients to tell their unique story only once, at their pace and in their time. We often hear from survivors of domestic violence and other forms of abuse that being asked to tell their story over and over again to different service providers is almost as bad as the initial assault.

TMC is a reliable and constant source of support, whether directly delivering support services or coordinating them alongside other professional services. TMC is the bridge that connects clients from culturally and linguistically diverse backgrounds to the professional support services they require. TMC provides a wraparound service—not the one-stop shop that is so urgently needed but as close to that as TMC can stretch its paid and voluntary staff.

TMC has the ability to be locally responsive, even in the most dire of circumstances. When COVID emerged in our community, TMC was the only local community service organisation whose doors remained open, providing COVID-safe services to our clients and others who had nowhere else to go.

As TMC has seen an alarming increase in clients presenting with mental health issues the organisation has responded by creating the TMC Living Room, a safe and welcoming environment for people to drop in and share their stories—the good stories and the not-so-good stories—over a cup of tea. 'I have a mental health issue' is not tattooed on anyone's forehead and clients often are not aware that what they see as their main problem is a symptom of an underlying issue—more often than not, a mental health issue. The clients who present to TMC do not come once; they come every time they have an issue. Why? Because TMC is a trusted service where clients feel a sense of belonging, where their unique life story is respected and where they as an individual are valued.

TMC does not have all the answers—far from it. It does not have a crystal ball to foretell what might trigger a mental health issue. But TMC can and does help its clients work out the steps that need to be taken to address their issues, supports them along the way and also helps them build resilience for when life throws them another curveball.

There are as many differences as there are cultural differences. There is no 'one size fits all'. However, for the purpose of this inquiry, the TMC would like to highlight two very important differences in working with clients from different cultural and linguistic backgrounds, as opposed to others in the broader community.

Firstly, some clients, including their children, arrived in Australia already suffering from mental health issues caused by forced relocation from countries where they have experienced trauma and, in some cases, torture. As a result, many suffer post-traumatic stress without even being aware of the impact it is having on their lives and the lives of their families. They just know that there is something wrong. On the Gold Coast there is only one doctor who specialises in caring for people suffering post-traumatic stress syndrome. The majority of clients can only be referred to Brisbane based services that, understandably, have very long waiting lists.

Secondly, in many culturally diverse communities speaking about mental health issues is taboo, much like it used to be taboo to speak about or even be seen living with a disability. Therefore, seeking help is impossible. TMC sees the impact of this particularly in female clients who are struggling with the settlement process due to issues of abuse and neglect by their partners.

We can improve mental service outcomes with better assessment prior to or, at the very least, on arrival to Australia. Refugees and humanitarian entrants undertake a medical assessment prior to entry to Australia but not a mental health assessment. This may not necessarily preclude their entry to Australia, but it would assist settlement services to be better informed and prepared. We can improve mental health outcomes by recognising that cross-cultural understanding is an essential component of successful service delivery. It is not always just about a person's ability to speak and understand English. TMC sees clients from countries where English is widely spoken and understood—for example, the Philippines—but there are significant cultural differences about a range of everyday issues such as marriage, finances and the treatment of women.

Many mainstream and specialist agencies do not know how to work with clients from culturally and linguistically diverse communities. If we look at this from a client perspective, many clients from those backgrounds do not know how to describe their situation and ask for assistance unless they can speak with someone who they feel will understand them to some extent. Asking a family member, often a child, to take the responsibility of communicating on behalf of the client with the service provider is not the solution but sadly often happens. This is not appropriate when the client presents with a basic issue let alone when presenting with complex underlying mental health issues.

We can improve mental health outcomes by acknowledging the value and authenticity of the lived experience. The lived experience of TMC staff and volunteers is as migrants and refugees themselves.

CHAIR: We might have to stop you there as we do need to get to some questions.

Ms Blazevic: Absolutely.

CHAIR: Can I go to you, Jamila, and the folks from QPASTT? You said you have 500 on your waiting list at any given time. You said there are constraints on your capacity. What are those constraints and how do we deal with those?

Ms Padhee: The main constraints are just resource constraints.

CHAIR: Money or people?

Ms Padhee: Mainly money. Admittedly in the regions we sometimes do find it difficult to recruit staff. That is often because we are having to compete with a range of agencies. We work in Cairns and Townsville as well as Toowoomba. Toowoomba is not so bad, but in Cairns and Townsville we do sometimes find it a little bit difficult to find specialist staff. On the whole, it is resources. As a result of COVID we have had about a 230 per cent increase in referrals to our service, so we just have not been able to keep pace in terms of our resourcing.

CHAIR: Do the people who are seeking assistance from your organisation also seek it from other mental health providers?

Ms Padhee: I think when people become very acute they access the public mental health system. I think often people are also accessing—or attempt to access—private psychologists. We have story after story of people, through Better Access and other programs, attempting to see mainstream psychologists, social workers et cetera. However, they often do not use interpreters and they do not understand the refugee trauma experience, so repeatedly we will have referrals back to us. One instance I heard of recently in Toowoomba was of a young Yazidi person who attempted to access a private psychologist. The psychologist stopped partway through and said, 'Sorry, I can't help you,' and the referral came back. The key thing about QPASTT is that we are a specialist agency in terms of refugee trauma recovery. Our staff are highly skilled in terms of refugee trauma recovery. It is our everything.

CHAIR: Magdalena or Zainab, oftentimes there are people in communities who have worked and have qualifications in various areas like health care who are not able to work because they cannot meet the requirements to be registered in Australia. Is that a common thing? Do we have people out there who could be engaged to work in the mental health field who are not engaged at present?

Ms Kuyang: Do you mean in terms of people who have studied?

CHAIR: Yes.

Ms Kuyang: Yes, there are situations where some people—a few—are able to find a job in the career they have studied, but the majority find a lot of difficulties in finding jobs for reasons they do not understand.

Ms Padhee: Zainab might want to talk specifically about the situation for asylum seekers, who do not have work rights.

Ms Sakha: I came here to Australia in 2011 as an asylum seeker and we were detained for four months on Christmas Island. I came here with my husband. At the time we came to Brisbane we were not allowed to study or have work rights for four years, until 2015. Now my husband and I have two daughters, one aged seven and one aged five, and they are going to school. For a few months they were not in the system because they were labelled stateless or illegal kids here in Logan Hospital because we were not residents. Of course, one of the parents must be a resident when the child is born. This is the only home that my kids have known and they believe they are Queenslanders.

Ms Padhee: One of the key issues for people seeking asylum—there are a number of people who are qualified but because they are seeking asylum they often do not have work rights. There is a tragic story of a medically qualified doctor who was an asylum seeker who actually committed suicide in Queensland. Obviously I understand that is not related to Queensland government policy; that is federal government policy, but it is a real thing in the community.

CHAIR: It seems like a lost opportunity in terms of workforce. In terms of the migrant centre, I was interested in your submission; you talked about the planning process. Do you have input into the planning of mental health or general health services in the Gold Coast with the HHS and the PHN there?

Ms Zubac: That was the main plan. I just wanted to bring your attention back to the submission. The main issue we have is that the services we provide we are literally improvising. We do not have much, but to put things together since 2004 we accommodated so many of them. The main point is that centralised services are not doing us any favours. It might be cost-effective for government or governments, but the main solution we see is in seeing who is who in that planning process and service delivery without double dipping or putting services together or multiplying services. I am talking about services that do not exist on the Gold Coast.

There used to be a mental health association of Australia. It existed until 2004, when they disappeared. Since then we have only multicultural mental health funded by the Queensland government with Bernard Kanputich. After Bernard retired a year and a half ago we lost all contacts.

What I am trying to say is that we have skilled persons and we have workers; we do not have funding or acknowledgement. I do not want to talk about settlement services because settlement is the federal level. If we were supported in a bipartisan way in our initiative and we could put forces together, maybe with a small segment on arrival we could implement a mental health assessment and do something about it. We are missing out on added value with every single client. That is the response to the question you asked my colleague from QPASTT. We do have counsellors, doctors and professionals and we are not using them.

Mr O'ROURKE: Jamila, I am thinking from a rural and regional Queensland perspective about the very important work that your organisation does. How do people in my area, for example, access your services? Are they available?

Ms Padhee: At the moment I know in Rockhampton there are big communities working at the meatworks, for example. If we had a number of clients that were needing our assistance, we would ensure there is a worker there. One of the benefits of COVID is that we have actually set up much better systems in terms of telehealth. At the moment for Rockhampton we would probably need to do telehealth unless there was a really serious situation or a number of clients. One of the things we are looking at currently is opening up an office in Rockhampton, but that would be linked to settlement and what is happening in terms of settlement.

Dr ROWAN: Thanks to both organisations for the work you do and your submissions, particularly those powerful stories profiling particular individuals and not only their personal experiences but also the contributions that have been made. It was terrific to read all of that in those submissions. I have two quick questions. The first one is to Thriving Multicultural Communities. In relation to the Queensland government's community and neighbourhood centres that exist, are there any particular opportunities or recommendations you would have as to how they could further be utilised for collaboration and coordination to improve access to information and services that exist and/or other things that need to be done to improve outcomes for people with either trauma related issues or mental health conditions?

Ms Zubac: I will say a few lines and then I will ask my colleague Joyce to respond to that. For your understanding and convenience, we grouped the services into a few different areas. In terms of migrants, as Gordana says, we cannot have one service that can fit all. We needed to separate and divide them. That cultural competency and understanding of different cultures was crucial in order to service them. Yes, we do have a plan and we will present that plan to you. We have an excellent plan. We even contacted Commissioner Frkovic. He visited us. We discussed all obstacles and all solutions for the current problems. We are on the same page and you will be contacted with that detailed plan; that will be sent to all panel members. I will ask Joyce to answer the question.

Ms Cho: Yes, there are opportunities to collaborate with the community centres and neighbourhood centres. However, these centres do not have the same reach with refugee groups as we do. We are known on the Gold Coast as the first stop, a, one-stop shop, not just because of our programs but because of our long-established reputation. As a settlement worker, I would like to share my experience regarding refugees in particular. For them, mental health issues become their normal. This so-called norm can be triggered by things like COVID, floods, bushfires or financial stress. Without realising it, they live their lives in this state of normal which is easily triggered. I feel we have squandered the opportunity by not helping them to live to their potential.

Mr MOLHOEK: I am just declaring an interest. TMC are actually in my electorate, so I have a little bit to do with all of you. Thanks for coming today. My question is probably to both groups. Gordana, you opened with the statement that a visa represents a promise of a better future. I have seen on many occasions where people have gone through incredibly long, drawn-out processes around visas. Depending on the status of the visa—and I think you touched on this, Zainab—it can be quite discriminatory in that they can be waiting for weeks, months if not years, as you have spoken of, just to get their kids into school, be allowed to work, access a Medicare card and receive health services when they really do not have the income or the financial capacity to meet those needs. Does the visa process itself create levels of mental anxiety and mental health amongst many migrant families?

Ms Cho: Yes, absolutely. We have families who are broken apart, and sometimes you have the husband waiting here and the wife is back there and it has been four years, five years, six years. In the meantime, she has moved on because she has had to. She is in a refugee camp and the husband is here. Then you get the reverse—where the partner is so distressed that she has committed suicide. That was a significant problem for that family and created a lot of community trauma. It does happen.

Mr MOLHOEK: From my understanding, even the process itself means it is quite difficult to contact the department. You lodge your application and you just get a message saying that the processing time is 24 to 38 months and you have no ability to even get answers around that. What is the impact of that?

Ms Sakha: There are two parts. I will just use myself as an example. I came here as a refugee, and that was a long journey after the trauma that I had been through. That is one part. The other part is that I came here in 2011. On the same day that I arrived here, the policy has been changed and they call it a 'no advantage' policy. Under that part, I have been living here in Australia in Queensland for more than 10 years and still my life is on hold.

Ms Padhee: I just want to say that Zainab's children have grown up here. They are Queenslanders. It is all they know but they do not have a visa.

Mrs McMAHON: Thank you for your work. I represent a portion of Logan, which as we know is one of Australia's most multiculturally diverse cities. The stories that I am hearing are stories that I hear through my electorate office on a regular basis, so thank you for the work you are doing within the space. I was interested to hear about the settlement process, and this goes on from what the member for Southport was referring to. The goalposts keep changing, time lines keep getting pushed out and families are further separated. Gordana, you mentioned something about there being medical screening but there is not mental health screening. It sounds like a good idea but it also sounds like a reason for people to be rejected under particular types of policies. One might think doing that might become restrictive and therefore people would seek to hide or disguise. Could you comment on the pros and cons of something like that?

Ms Zubac: Australia as a country signed a contract with the UNHCR and we accepted refugees from war affected regions, which means it is likely that we accept people with PTSD. They are not coming from Hollywood; they are being exposed to all sorts of trauma. It is normal that they will be affected but what we point to is that, once they are defined, we can allocate services that will help them. It will not cure them very often but it will help them live with that and achieve their potential.

Mrs McMAHON: In your submission you identified the solution of establishing a Gold Coast mental health unit for CALD people. Is that done anywhere else in Queensland, or is it done in any jurisdiction that the committee could look at?

Ms Zubac: It is not known to me. We are not aware of that. I called this idea a pilot project so we can follow up on that and have it for a couple of years. They are usually under a five-year strategic plan. We are going to present you with that, as I promised Dr Rowan, and then we will see how successful that is. We will be monitoring it and obviously if the results are there you will be notified.

Mrs McMAHON: Are you proposing a five-year pilot within the Gold Coast HHS?

Ms Zubac: Yes. I am proposing that because we do not have it and it is of essential importance to have that.

Mrs McMAHON: What kinds of resources would you require to get that on the Gold Coast—just focusing on the area that you know? What would that look like on the ground in terms of staff, space et cetera?

Ms Zubac: I will send the plan in a proposal to the committee. The idea is there; a plan is done, even an operational plan. As I said previously, because we contacted Commissioner Frkovic, we have people who are already on our board and it is ready to go, basically. It is just looking for the resources and finances. Since I came to the migrant centre in 2004 we have been doing that on a volunteering basis, except for a few small projects that we receive from Queensland mental health just to raise awareness about mental health. That happened recently. I think three or four years ago we got one lot of funding for $10,000 plus GST, and another one was around $6,000, to raise awareness about mental health issues.

Dr ROWAN: I want to come back to the Queensland Program of Assistance to Survivors of Torture and Trauma and clarify that 230 per cent increase in referrals to your service over the duration of the COVID-19 pandemic. I want to get a sense of what is happening. Are there issues around financial stress, relationships or health? What are you seeing amongst that increase? That is a substantial increase you are having to deal with. What are the specific issues that you are seeing?

Ms Padhee: There is no doubt that there have been enormous stressors as a result of COVID. What we have seen is that many people who probably had moderate symptoms have now moved into needing support. A lot of people who did not need assistance, who were coping, are now needing that support and that is what has really increased our numbers. For us also, what simultaneously happened is that there have been a number of major international crises—the situation in Burma, the situation in Ethiopia and now the situations in Afghanistan and Ukraine. That has also been layered on top.

For people seeking asylum, the situation is getting harder and harder. Together with the World Wellness Group—I think they will present after us—we have been fortunate to deliver a program funded by Queensland Health, but the uncertainty for us is that that expires on 30 June. We have been able to support about 150 people since the inception of the program. In some of those populations, the impact of COVID has been magnified—not COVID itself but the loss of employment which has led to a loss of housing and a whole range of things. There are all these additional stressors.

Dr ROWAN: What is the name of that program which is due to expire on 30 June? How long is the funding cycle normally?

Ms Padhee: It is the Asylum Seeker Mental Health Rapid Response program. We will have had funding for about 18 months, and it goes six months to six months. I acknowledge the department is trying very hard to find funds, but it just goes six months to six months.

CHAIR: I do not want to get too far into migration policy because it is outside the scope of this inquiry and it is well outside the jurisdiction of this government. It is undeniable that there have been significant changes in approach to migration policy. Even with the recent issues that have generated the need for people to seek asylum, there seems to be some differences in the way that we approach those—in that people from Ukraine are being quite rightly welcomed but people from Myanmar or Ethiopia are not so much. That uncertainty and instability around government policy around these things must have an impact on people's mental health. Can you comment on that?

Ms Padhee: I think it absolutely has a direct impact on people's mental health. I have a quick story. One of our clients at QPASTT is a young man—he is 25 now—who arrived in Australia by boat when he was 12. He has had tremendous resilience, but the thing that broke him was: soon after the fires he decided that he wanted to help out so he went to join his local SES at Daisy Hill. He is a young asylum seeker from Iraq. At the initial meeting they said, 'Yes, you can join.' Then when he had to present his residency documents they said, 'No, you're not a resident of Queensland. You can't join the SES.' That is what broke him and made him lose hope.

Often that is not intentional government policy but it has its impact. People are facing that all day, every day, even when they go to the hospital and there are letters that we can give them. The World Wellness Group will talk about this more, but they front up to hospital and are given bills. That just reinforces again and again that they are not equal in Queensland.

Ms Zubac: I agree with the statement. As settlement providers, we see that on a daily basis. New contingents of migrants will arrive soon, and we have received some indication. We have clients from Russia and Ukraine—internet marriages. We have a lot of Ukraine brides and grooms. We are already dealing and working with people of that background. For their settlements we are prepared and ready, but as far as Ethiopians and the number of visas being approved we have already fulfilled that requirement. The uniting families is a completely different visa. They can apply for that. Obviously, the waiting period is longer now post COVID, on top of everything. They will be extended. I am always going back to what we proposed in our paper—that if they are sad, happy or experiencing issues, they need to have a place where they can come and we can deal with them, make them feel comfortable, wait with them together.

CHAIR: We have talked a lot about mental health. I assume that people come looking for assistance around alcohol and other drug issues as well.

Ms Padhee: Absolutely.

CHAIR: What is the capacity of your organisations to respond to that?

Ms Padhee: We work closely with alcohol and other drug agencies. It is a resource issue—just how far we can stretch. Again, in the asylum seeker space, that is where we work closely with World Wellness Group. QPASST would refer to World Wellness Group in that situation in the asylum seeker context.

Ms Blazevic: At TMC we see a lot of clients who have multiple issues. You are quite right that we are only talking about mental health issues today, but that is all part of it. The issue that I think is connected to that is the fact that we are concerned about this becoming an intergenerational problem. We have adults who have these issues who have kids who are growing up with that as their example. We know from other areas that where we allow things to slip it becomes a generational thing—like unemployment in certain areas. We do not want this to become an intergenerational problem as well.

You are quite right that it is from the beginning of the process through to the end of the process. Whilst some things are a federal government responsibility and others are a state government responsibility, unless there is a continuum of agreed standards of service delivery and support, people will fall through the cracks. We take your point, but we hope that you will also raise with your federal colleagues the issue of there being some connection between what is their responsibility and what is the state's responsibility, because the buck will stop with the state because that is where the people are.

Ms Zubac: If we didn't help many clients so far, let us make a difference for the future generation.

CHAIR: That is a good point to end it on. I would like to thank both organisations for coming and presenting today. Your submissions and your evidence here today have been really useful. It will help to inform our committee's work as we go forward. I want to thank all of you, your staff and volunteers for the work they do. It has been a tough couple of years with COVID and we know it has been particularly tough on health workers. As we have seen with the Ukrainian situation, there is going to need to be generosity in Australia for migrants and refugees going forward. Thank you for the great work you do in that space.

CHUA, Dr David, Research, Audits and Collaboration Manager, Inala Primary Care (via videoconference)

CHUA, Dr Stephanie, General Practitioner, Inala Primary Care (via videoconference)

JOHNSON, Ms Tracey, Chief Executive Officer, Inala Primary Care

PRASAD-ILDES, Ms Rita, Managing Director, World Wellness Group

SULEMAN, Ms Sameera, Manager, Multicultural Connect Line, World Wellness Group

VAYANI, Mr Hamzai, Chair and Board Director, World Wellness Group

CHAIR: Welcome. I declare an interest—I do not think it is not on my register of interests—that I do volunteer work as a registered nurse at the World Wellness Group. I would like to invite each organisation to make a very brief opening statement and then we will go to the committee for questions.

Ms Prasad-Ildes: I appear on behalf of World Wellness Group—WWG, as we call it—a specialist multicultural primary healthcare service with my colleagues Hamzai, chair of our board, and Sameera, manager of the Multicultural Connect Line, which is one of our Queensland Health funded mental health services. We represent the more than one in five Queenslanders—over a million people—who are born overseas in more than 200 countries and the one in 10 Queenslanders who speak one of the 180 languages other than English at home.

As a specialist primary healthcare service which has served over 11,000 people from 145 ethnicities and with over 45 per cent of our service contacts being mental health focused, we can speak from direct experience that the poorer mental health and mental health outcomes for people from culturally and linguistically diverse backgrounds is due to a complex mix of inequity and access barriers and a disproportionate impact of the social determinants and the diverse cultural beliefs and experience about mental illness, resulting in higher levels of stigma.

Our health service system, with the overstretched mental health services, does not respond adequately to these issues, and the inequities, which are largely systemic, become further entrenched. The COVID pandemic has starkly highlighted the disproportionate impact on the multicultural population, with the recently released ABS COVID deaths data showing the death rate for the overseas born population in Australia being three times higher than for the Australian born population—in some communities, such as Middle Eastern, 30 times higher. This is largely attributable to the inequities in the healthcare system which extend to mental health care. This is even more concerning with mental health impacts of the pandemic. At WWG we have experienced an over 200 per cent increase in mental health referrals since 2020.

As stated in our submission, our key concern is inequity in mental health care. Inequity arises out of an under-representation of diversity in the workforce, particularly amongst decision-makers, and resource and funding allocations which do not address the specific needs of the underserved and marginalised populations and therefore continue to further entrench inequity. As one of the major multicultural mental health providers in Queensland, we are frustrated that there are no direct funding pathways. All our funded mental health programs are a result of our direct advocacy and not due to identified government priorities.

The mental health profile of Queensland's multicultural population demonstrates significant disparity. Queensland Health's own documents reveal an over-representation in acute mental health services, higher involuntary treatment orders—in fact, 40 per cent higher—three times more likely to be treated on a forensic order and less likely to be followed up after discharge.

The CALD population's contact with the mental health system is overwhelmingly at the acute end and needs to be turned around with greater investment in community based services and prevention and early intervention services. Our submission has identified a number of immediate opportunities that are available and we will be pleased to answer any questions about those.

Dr D Chua: There are a lot of things there that mirror in our submission as well. Thank you to the committee for having us. I am Dr David Chua, Research, Audits and Collaboration Manager. Tracey Johnson, our CEO, and Dr Stephanie Chua, one of our dedicated GPs, are here with me.

As you know, Inala Primary Care is a not-for-profit general practice located in Inala. We serve approximately 7,000 patients, 4,400 of whom attend our clinic regularly. Our mission is to deliver equitable quality primary care and to champion better ways to deliver primary care and advocate for change. We invest in these pursuits on top of our clinical work because of the vulnerability we see in our diverse yet marginalised community.

Our patients, many of whom have multicultural backgrounds, have experienced lifelong trauma from systemic marginalisation, civil unrest or war. The proportion of people in our region with mental health problems is in the highest quintile in Australia. Australia's GPs provide over 80 per cent of Medicare billable mental health services, yet they are undersupported to do so due to limited escalation pathways available to them and what could be seen as financial disincentives to do longer, difficult medicine.

The ABS reported that the proportion of people with mental health conditions grew by 18 per cent between 2015 and 2018. The AIHW reported spikes in mental health service utilisation of up to 30 per cent during the pandemic lockdowns. Mental health is the fastest growing type of hospital admission in Australia. We have been in a crisis for years. This is not hyperbole; this is compounded by historic policy inaction and current world events. Many people are being pushed over the edge.

People with psychiatric problems have shorter life expectancies—an average of 20 years for males and 15 years for females—and this is associated with increased rates of cardiovascular and respiratory diseases and cancer. People living with mental health conditions suffer from reduced quality of life. The many medications for their condition cause side effects which further increase chronic disease risk.

In our submission we highlighted eight key areas where immediate change or extended support is needed. These were: improving low-intensity mental health counselling and psychology to intervene early and prevent the need for future intensive interventions; better support for mental health and wellbeing in younger people, because we know that most mental health conditions develop before the age of 25, including continued support of parenting programs; and deeper collaboration with general practice to increase visibility and accessibility to our patients for these programs. We also ask for timelier access to support for child abuse survivors. We personally know of families who have abandoned trying to access these services due to lengthy wait times of up to two months. This is not acceptable and only cements lifelong psychological problems.

We ask for better suicide support and better support for GPs to find appropriate, timely and accessible escalation pathways when patients present in crisis out our clinic. We ask for improved access to psychology services. We know that marginalised people are more likely to suffer from mental health conditions. Private psychology is often out of reach, and publicly funded psychology has lengthy wait times. Limitations on the number of visits mean little effective, evidence based therapy can occur anyway. Trauma services for people from culturally and linguistically diverse backgrounds provided by QPASTT and QTMHC are well and good, but both suffer from extremely long wait times. Expanded service funding is required to reduce these times.

We ask for investment in both social care and healthcare coordination services, because our health outcomes are determined by our own social circumstances and our own health system's knowledge and navigation skills. Public psychiatry outpatients currently is overburdened. Only the most severe cases are seen. This leaves many without access to care which they desperately need. We also suggested improving perinatal depression support, mental health nurse navigator models and discharge communications for GPs for patients leaving psychiatric hospital care. We also support commitment to community and social cohesion projects through reduced social isolation and enhanced wellbeing.

We welcome this inquiry and thank you having us. Action is required at all levels of government and across agencies. Our communities need integrated healthcare precincts where patients and their GPs have required services close by. Concerted mental healthcare reforms will undoubtedly have society-wide impacts. Thank you for having us. We welcome your interest and inquiries.

CHAIR: To both organisations, thank you. I will start with questions for Inala Primary Care, particularly around GPs. Reform in the GP area again sits outside of the jurisdiction of the state government, but we are interested in it. I know, from reading patient charts and other matters, when I have been doing work at the World Wellness Group, particularly of those people coming from a refugee or migrant background, that I look at what the GPs are doing with the folks who are coming through who have mental health issues, and even some of the young students that come through with mental health issues. There is absolutely no way that those people could be provided with any decent level of care in six minutes. If we could change things in general practice to provide better care for people with mental health, what would those changes look like?

Ms Johnson: I might lead off and then hand over to Steph, one of our GPs. I think at the federal level there are a couple of changes coming. The government announced a preventive health strategy in December that is predicated on an awful lot more money going into preventive health. I think we all acknowledge—all of us who are clinicians, and I note the end of that table is largely clinical—that preventive health in this country has been under-resourced for decades in comparison to overseas. Mental health is a really strong theme, and social prescribing and care navigation and early intervention in vulnerable families and migrant communities are repeating strains through that entire preventive health strategy. Holding the Commonwealth government accountable to what that strategy says it is going to deliver by 2030 is vital. Ensuring that a good amount of that money goes into primary care where early recognition, response and resourcing is required is something that we all need to be championing.

The second theme of work that the Commonwealth has been engaged in for some time is looking at a 10-year health reform strategy for primary care. Mental health is one of the strong themes in that strategy, and we are privileged to have been part of the consultation around that in terms of mental health, migrant health and chronic disease care. I think the arrival of bundled funding—which is risk-stratified based on whether patients have a migrant background, a mental health issue, live alone and all of those sorts of things, where we get recognition of the presentation as well as the person—will fundamentally change the way care and primary care is delivered and get away from that, I agree, terrible scourge that we have, which is six-minute medicine occurring in general practice.

That said, there are many doctors out there. Steph is one of them. We have two doctors in our practice who are doing short interventions for mental health. They are GPs who provide much longer consultations. They have done additional training in mental health skills, so it does exist. It is more a case of whether there is a commitment from the practice and the clinician and whether it can be cross-subsidised, which in many instances is very difficult. Our GPs get less; that is the harsh reality. Our staff get paid less. They take on more stress. You can go and do a lot easier medicine elsewhere than in Inala. That is not fair, which is why we need to be arguing for more appropriate restratified bundled funding.

CHAIR: You mentioned bundled healthcare funding. Have the details of that been finalised?

Ms Johnson: No, they have not. We have been waiting for those details to be released by the Commonwealth. There were a number of draft consultation papers that came out last year. We are waiting for Greg Hunt to do the big reveal.

CHAIR: The broad concept would be greater funding based on the circumstances of the patient rather than a one-size-fits-all approach and you make it work whether it works or not.

Ms Johnson: Absolutely.

Dr S Chua: Yes, I certainly agree. I think the biggest issue is the time limits that we have and the fact that GPs are naturally disincentivised from seeing more complex patients or spending time with them because of the way the MBS funding is. I think if GPs could have better support in being able to delegate some of the tasks that would help patients with mental health problems that would be really helpful. A particular example would be link workers or mental health nurses. These are people who can really support GPs and provide a lot of that extra help and do things that take extra time but not necessarily using the GPs' time.

As we mentioned in our submission, a significant issue for a lot of our patients is the social aspects that really impact their mental health and their physical wellbeing. These are things that GPs are not really well placed to deal with but they are kind of the only ones who can, even though they are not the best option. These are issues with housing, for example, issues with finances. As GPs we do our best, but that could be provided with the help of a social worker or a mental health nurse who can help them with those situations. It would make better use of funding as a whole because we are utilising GPs' skills and time better and are not running around trying to do all these other things that we know are really important. Certainly people are not going to improve if you have all of these other social aspects that are not being fixed, but the current system does not allow GPs to really do that well. I think that is a really key part of what could help.

Ms Johnson: The other thing I would add is just in relation to getting a diagnosis. For some of our patients we cannot unlock the NDIS and we cannot unlock access to all sorts of other care services until we actually get a diagnosis. While I am incredibly privileged to work with a team of 15 GPs who are highly skilled and highly committed, in all instances they are either not able to give a diagnosis or their diagnosis is not recognised if it is suspected. Our ability to get patients in to see a psychiatrist publicly or privately and actually get that diagnosis so we can then move the rest of the way through the system is disgraceful. It really does impede people getting access to the care they need.

CHAIR: To the folks from WWG, I know you have your GP clinic and your culture and mind service as well. Does that provide some capacity for your GPs to refer people straight on to culture and mind and get those slightly more complex services for people who would not be sick enough to end up in a public hospital but who do need some intervention?

Ms Prasad-Ildes: Absolutely. I think we are fortunate, and I think it was a very intentional way we structured our service. We knew that a multicultural primary healthcare service could not be set up without these support services. Our GPs are very much a team, but as I said in my opening statement it has taken a lot of advocacy on our part to get these types of mental health support services funded by both Queensland Health and the primary healthcare networks to support the GPs with that type of work. It is absolutely beyond their scope and I think we would not retain GPs. As Tracey said, it is not easy medicine to work in this field, so you need to be part of a team where you share the load and do that work.

CHAIR: I know you did not necessarily touch on it in your submission, but I know it exists. The Institute for Urban Indigenous Health appeared before the committee today, and they have also gone down the path of having a health justice wing. I know you have gone down that path. Could you step the committee through the health justice program?

Ms Prasad-Ildes: Health justice is an internationally validated model. It originated in the United States, where it was founded. A lot of disadvantaged people have legal issues that impact on their health and they take up a lot of health practitioners' time for advocacy and support letters. Health justice is a model where a lawyer is embedded in the healthcare team. World Wellness Group has self-funded that through various tireless fundraising efforts where we continue to have a lawyer working with us. We have really fantastic partnerships with community legal services like Caxton, but it still remains an unfunded program. I think it typically is an example of where there is not a clear funding pathway, but the outcomes we have been able to achieve have been really quite significant and impact on improving people's mental health because their legal issues are taken care of.

Dr ROWAN: Just to follow up on the line of questioning from the chair around the health justice program. You mentioned in your original submission or testimony today about the high number of people from multicultural and linguistically diverse backgrounds who may be on involuntary treatment orders or forensic mental health orders and whether there should there be some reporting of that information through those health justice programs—even the ones that you run or that are run through the community legal services—should information be provided back to the Queensland Human Rights Commission to get an oversight from a data perspective as to what is happening there. If you believe that would be helpful, what would that look like?

Ms Prasad-Ildes: Absolutely. The human rights framework underpinning all of this work is absolutely essential. Health justice falls in that sphere. I think those statistics are really damning in terms of the over-representation in a sort of more coercive end of the mental health system. I know there are patients' rights initiatives, but it really takes a more proactive and assertive legal approach. The majority of our clients in our health justice program have mental illness, and it takes a combination of social workers and lawyers working together to keep people engaged in these legal processes. Absolutely, that would be a strong recommendation from us.

Dr ROWAN: Rita, in your opening comments you mentioned access barriers and inequity in mental health care and increasing that diversity in the health workforce. Do you have any recommendations as to strategies that Queensland Health could implement to improve the diversity in the health workforce that exists within our public health system? I am happy for Inala Primary Care to answer that.

Ms Prasad-Ildes: I might defer to Hamza on that because he may have been at meetings about this.

Mr Vayani: Thank you very much for the opportunity to present here today. There are a few things I want to say around the workforce and also build on the comments that were made previously around service access and funding. Before we get to the workforce question, in terms of data, if you are talking about data to expose inequity, first of all we have to have a more sophisticated conversation in this state and even nationally around what data we should be collecting and how that is utilised. We do some advocacy around that and we have had a couple of roundtable discussions. In our submission you will have noted that, whilst we touched on it at a surface level, really what we need to get to is a point around when we are looking at health inequities, social determinants and then identification of ethnicity and other relevant variables, you have to know what we are collecting and why, then how we are going to use that as a measurement basis to understand what the disparities are and then drive improvement. At the end of the day we all know there are finite dollars, and if you are going to invest in this and you want to see a shift in the dial then you have to have some basis on which to hang your assumptions from. I think that is point No. 1.

Point No. 2 is that I think there is an opportunity structurally. We know the vagaries of Federation, but I think one of the opportunities that we have, noting the terms of reference of this committee—other jurisdictions have just done it recently such as New South Wales—is to enter into bilateral agreements. I think there are opportunities structurally to take the best of what we have here in Queensland and what has been talked about at the Commonwealth level in terms of what Tracey was talking about around bundled payments, incentivising and the need to basically address market failure where whole population segments such as our population group is not really systematically thought through or recognised in terms of funding criteria or bundled payments and so on.

Going back to your workforce question, let's say we were to fix all of those things: we fixed the bilateral agreement, we had the right measurement and we said we were going to reorientate funding. That creates a wicked problem in and of itself—and we have experienced that firsthand—the wicked problem being you do the advocacy, you get a culture in mind, the service up and running, you get your general practice people coming in and your nursing people coming in. This is an area where you are trying to right-size complex medicine with funding and models that do not really reflect the complexity of the care that you are dealing with. It is a difficult proposition to get people into your workforce in the first place. Outside of that, let's say beyond people doing it for the love of it—and we have a lot of beautiful humanitarian people who understand what they are doing and taking that on—you also have issues around workforce shortages. This is an issue that crimps health care more broadly or mental health services more broadly.

How many times, Rita, have you, Sameera or I—and I am sure it is the same for Tracey—come across people who have come from overseas potentially hoping for an opportunity and who could be employed in the system? They could be some of the very best practitioners, clinically or even in terms of link workers because they have walked that journey and they might be able to deliver the accessible care we are looking at. But we have difficulties around their skills being recognised or translated so they work in a clinical workforce or support role. I will give you a really practical example of that. I know firsthand of people who have nursing qualifications, but it becomes really difficult for that to be recognised in an Australian context. They go from pillar to post. You have a situation where at Ahpra at the national level—and Queensland and the various states and territories are part of that regulatory framework—there is a lot of confusion around people who go through that. They may have prerequisite nursing skills that have been assessed as okay. Ahpra says, 'Yes, I can understand that. We now need you to provide 12 months worth of placement experience unless you are prepared to go and sit another qualification.' That qualification costs anything from $12,000 to $16,000, which is out of scope for an individual who might want to practise in our type of service. You put a huge barrier there and lose the skill and potential of someone who could do a lot of good and help supplement our workforce on one level.

Secondly, if they are reasonably skilled and able to navigate that process, the other pathway Ahpra tends to offer—and I am using nursing as the example I am aware of—is a clinical placement for 12 months. By the way, that clinical placement needs to happen in a hospital or health service setting; it cannot even happen in a primary care clinic. You have a potential workforce that you could draw on quite quickly by creating pathways, but the complexity around the national regulatory framework and what we—in terms of the nursing board in Queensland—approve with Ahpra are areas that require bilateral cooperation. If we could unlock that lost skill and potential, we could quite quickly deploy to start to shift some of the problems we are talking about.

CHAIR: One of the best wardies I ever worked with was an ICU doctor from a South-East Asian country who could not get registered in Australia.

Mr O'ROURKE: Tracey, I refer to your submission, dot point 3, and improved suicide support services. Especially at the time of crisis, while acknowledge the hotline services of Beyond Blue and so on, you also talk about there being still a significant gap in supporting and managing suicidal patients. Could you talk to that?

Ms Johnson: I might let Steph give the case studies. I can give them, but it is probably more powerfully told by the doctors who face that every day.

Dr S Chua: This is a really important point. I am glad that you have brought it up. There is a gap. We tend to find that patients are either considered not sick enough to go to hospital or they are extremely sick, they are really unwell, and there is nothing much in between. Hotline numbers are fantastic, but there are patients who will not use them at all. A good example is exactly what we have just spoken about: there is virtually no way you are going to get a person from a different cultural background, who does not speak English and is in acute crisis and suicidal, to use one of those hotlines. It just does not happen. You can hand out the hotline numbers as much as you want but it just does not happen in reality.

Then we have the issue where there is no simple escalation. It is either that they are in a community and they are fine or they are in a hospital and they are really sick. The problem when patients go to a hospital is that a hospital is built for physical problems; it is not built for mental health problems. Patients who are mentally unwell and suicidal end up in emergency and obviously they get the best care possible, but it is not really appropriate for them. The stories I hear are that patients will go to a hospital, they will wait for hours and hours, they eventually get seen by a mental health clinician at some godforsaken time in the morning and then they are told, 'No, you're not sick enough. You can go home.' That is really invalidating for them. They have just been put through the ringer. They feel like their mental health is not significant and that no-one is listening to them. It is a big problem.

A lot of community services clearly are just not resourced to have that crisis support as well. For example, even groups like headspace will specifically say, 'We are not a crisis support. If you need crisis support call triple zero.' Patients do not have anywhere in-between to go. If we could somehow bridge that gap that would be fantastic. If we could have timely intervention where someone could actually see someone, talk to them face to face, not necessarily in a hospital, then that could be really helpful.

Ms Johnson: I might add to that. We are not-for-profit so we have built some partnerships with some other not-for-profit groups. We have Footprints embedded in our practice; they provide social workers. We have Stride embedded in our practice; they provide mental health workers. Both of those models are funded by Brisbane South PHN. Both of those models are only funded because we spent years advocating for it and that takes a huge amount of my time, which is not funded by Medicare.

On top of that, when patients are corralled into those services that is great, but they are always over capacity and oversubscribed so we managed to get some money out of the Mater for a nurse specific care coordination model. Again, it is desperately oversubscribed. There is no ongoing funding and no ongoing support for some of these services that David has done the data validation around. He has a PhD for a reason. He can produce really good data on what is shown. But there is no ongoing support for those services from Queensland Health.

The other challenge we have is that patients present in crisis to an emergency department and, as Steph said, it is an unbundled presentation. As a general practice, their general practice, we get no notification that that patient has been there. Say they had been there at two o'clock in the morning and were told, 'You're fine, go home.' We should get a discharge summary that day so we can call them to say, 'I understand you were at the hospital last night. Would you like to come in and talk to somebody about that?' We get that much advice from them—zero—and it is often not until the patient discloses some days, weeks or months later that they have even had contact with the emergency department that we are aware of what has gone on. That needs to change.

CHAIR: I would like to point out that at that godforsaken time of the morning the nurses are still working. The nurses take over when God gives up.

Dr S Chua: I fully appreciate that and God bless all the nurses. I completely understand. It is a reflection of how stretched I think the whole system is that we are in this situation. I think that is the main issue.

CHAIR: Yes, absolutely. Sameera, you work as part of the Multicultural Connect Line, which is something, as I understand it, that has come about as a result of COVID. It is a bit of an outreach service where we are not waiting for people to contact us, although there is a bit of that; you are also reaching out to people in the community. Have there been any impacts in terms of picking up on people in distress or having anxiety that you have been able to then refer on to other services or bring into Culture in Mind?

Ms Suleman: I guess we did set up in the midst of the COVID pandemic. A lot of the work we were doing was very much at the intersect of that public health response to the COVID crisis and also the mental health impacts that the community were facing as a result of social hardships because of the pandemic. We managed to actually pull together a significant amount of data to evidence the need for ongoing support because we are able to reach out to communities and have community engagement workers out and about building trust associated with the service. From that initial set up of the health line we have become a pathway that people in multicultural communities across the state understand is a first point of call and a gateway to find supports. We are very purposeful in our messaging that we are here to provide you support if you are having practical difficulties.

However, what we understand is that this is the first step towards getting the mental health support that people critically need because people from multicultural communities experience emotional hardship as a result of the context that they are in, the situational issues that they are facing. It is not always an organic cause of their mental health issue. We can provide those initial links to some very practical supports, but also provide that ongoing brief intervention for people to really develop a relationship where they get to a point where they are actually comfortable to start talking about stress, anxiety and mental health issues, and that has really opened the lid on a lot of issues that people are facing across the state.

We have found that we are now getting calls that require clinical intervention quite immediately so we have had to engage acute care services. We have had to really rely on the support of the Queensland Transcultural Mental Health Centre for a lot of advocacy because it is very hard, as Dr Chua was saying, to get people into the system. The challenge that people from non-English speaking backgrounds and people who are newly arrived face is that you do not always know what information to share with health professionals. It is often a need for that advocacy and to provide people with some coaching and a framework about what information is important to share so you get the help that you need. Really we have been able to support people to access critical emergency care in terms of mental health and also provide a pathway that destigmatises accessing mental health support so we can do that initial low-intensity support and prevention work as well.

CHAIR: I want to talk to the issues around planning because I think they are really important. The Productivity Commission recommended a model of HHSs working with PHNs to do planning. Inala Primary Care, you are more of a traditional GP clinic.

Ms Johnson: I would not say that.

CHAIR: More of one than WWG—a little closer. I think about the PHN where my electorate is in metro south. Looking at the GP services within my electorate, and we will exclude WWG because they are a special case, in Coorparoo you might have a 120-year old family practice that does not take new patients because they have fourth and fifth generations going there. Then there may be a practice on Logan Road that is very busy, very big, has an emergency element to it and does methadone and other drug and alcohol services—big and lots of bulk-billing, lots of people in and out of those services. It would seem to me that the PHNs remit is so big and broad we actually need to drill down to the GP level to have GP clinics involved in that planning process.

Ms Johnson: I could not agree more. We have advocated strongly for many years that the needs assessment process that PHNs are funded to do only occurs every three years. I think there are 326 GP practices in the Brisbane South Primary Health Network region. I think more of them are engaged with the PHN now that they have to provide data as part of a quality incentive initiative that the Commonwealth set up. Before that a heap of practices did not even have any contact with the PHN. We have tried to have contact with the PHN over the years.

Whilst as an organisation they have a pretty significant budget, their amount of money for flexible funding is tiny, truly tiny—a couple of million dollars a year, spread across a region with millions of people in it. It really does not give them much chance to do anything. From our perspective, when we have asked them to commission specific services often they will be able to fund elements of that service but we still have to wear the cost of the room, the telephone, the reception and everything else, so we still end up running those services at a loss but for the benefit of the patient.

I think the other frustration is that they might be able to identify needs. You asked before what can Queensland Health do and we had the previous question about what can we do to address providing more ethnically appropriate services. Our psychologist had been with us for eight years. She has the capacity to speak Spanish because she is from South America. She was serving our El Salvadorian and Chilean population. We have 376 patients who escaped war-torn strife in both of those countries. We have done huge amounts of research and publishing on the needs of that group because they have been here for a long time and their health outcomes are appalling. But you try finding a Spanish-speaking psychologist that can deal with their mental health issues. There is one. She resigned a couple of weeks ago; her last day was yesterday. Why did she resign? Because on average she has a higher no-show rate in our practice because it is bulk-billed care so she spends time doing nothing because patients with mental health issues in our community can be not great at turning up for every appointment. That is just part of what we are dealing with. On average she was billing $65 an hour, three days a week with us. If she is working, which she did, the other two days in a more affluent suburb she is billing $220 an hour.

In terms of looking at the health workforce, I would argue that our psychologists are the most differentially paid when they are working in low SES multicultural communities—even more so than my GPs and I know they take a hit. I know I took a hit when I came to work in our practice et cetera.

When you look at what a normal psychologist earns versus a psychologist working in any of these services, which are often funded under short-term contracts by Queensland Health or the PHN, they are paid peanuts or they bulk-bill like Andrea did for eight long years. Now that her kids are getting old enough to go to private high schools and stuff she has said, ‘You know what? I’ve done my bit. I need to go and work somewhere else for real money’, and that is a fair call. She has done her time. But why didn’t we support her financially to continue to do it by funding her some extra dollars in the community, which Queensland Health could provide or the PHN could provide? All of a sudden we have lost a resource and, to be honest, we are not quite sure what we are going to do with her patient load when she was there three days a week as a psychologist.

Dr D Chua: I think it is also really important to highlight that psychology is not a field that the Australian Free Interpreting Service provides services for. In Brisbane South PHN they can access that through the allied health interpreting service scheme that they have, but we are talking about Australia wide: they cannot use interpreting services. It is also important to highlight that different cultures have different ideas of wellness and health so the importance of bi-cultural workers in those areas is paramount.

CHAIR: You make a good point. I think back to my time at QEII where we had many multicultural patients. The use of interpreters was limited to narrow discussions where there were concrete and obvious decisions to make. The more complex conversations often either did not happen or happened with the assistance of staff who were not technically interpreters.

Dr ROWAN: Returning to Inala Primary Care: can you comment on the indexation of the Medicare Benefits Schedule for mental health items around case conferencing, mental health care plans and any reforms that are needed?

Ms Johnson: I do not want indexation; I want wholesale reform of what those item numbers pay. Frankly, indexation has eroded those item numbers to the value of about 26 per cent over the past ten years or so, which is significant. The reality is that we are being asked to do more and more of that work for patients who are increasingly complicated. In the last week, we had a number of patients present who are clearly acopic. The floods threw them into an absolute tizz. One of them lay on the floor and refused to move. Another one lay on an examination couch and refused to move. They were in great distress. There was not a whole lot we could do with them. Both have refused mental health care plans.

We need to remember that patients have a choice under the Medicare system. Both chronic disease care planning and mental health care planning is a consent process by the patient. If the patient chooses not to engage—and a disproportionate group of our multicultural patients and our very low-literacy patients refuse to engage in those areas of care. All of a sudden, those bigger item numbers that pay for us to spend more time with the patient and bring in the nurses—we have a very large team of nurses in our practice—are unavailable to us. To me, that is a nonsense. I agree that patient consent is vital, but we need to be able to trigger access to a mental health care system for patients who know, fear or worry about what that billing might do to their health insurance or to their capacity to work and all of those sorts of things. That is a really serious issue that we need to consider. I actually think we need wholesale change to the way that the Medicare system works.

CHAIR: That is a good point to finish on. We could continue these discussions for many hours, I am sure. I would like to thank you all for your presentations this afternoon. Your evidence will be useful. Your submissions are very to the point and will certainly inform our report and our recommendations going forward. Hopefully, that will make some improvement to the lives of people with mental health issues and alcohol and other drug issues.

The committee would like to thank your staff, your volunteers and all who have worked over the past couple of years during the pandemic. It has been an extremely difficult time. We acknowledge the World Wellness Group and the multicultural and international aspect of your work. We acknowledge the very significantly high numbers of health workers who have died as a result of COVID-19 in countries around the world. Thank you for the work that you have done and thank you for your appearance here this afternoon.

DELL, Mr Tony, Founder, Stand Tall for PTS

CHAIR: I now welcome Mr Tony Dell, the founder of Stand Tall for PTS. Tony, would like to give us a brief opening statement and then the committee members will then have some questions.

Mr Dell: After hearing the previous speakers, I think I am out of my depth in terms of medical knowledge. I will cover what I do now and why I am here. Thank you for letting me speak with you today. I am honoured to be here.

Mental health covers a vast landscape and post-traumatic stress is part of that landscape. While countries around the world, including ours, have made advances in recognising and tackling PTSD, we must recognise that sadly it is likely to always be with us. I have been proud to represent Australia in Test cricket. The downside of that chapter of my life is the physical toll that training and playing inflicts on the human body, which now catches up with me.

I was a national serviceman in Vietnam in 1967 and 1968. It was a chapter of my life which left me physically uninjured but mentally scarred—although I did not know it for 40 years. I did not know I had PTSD. I just thought I was jinxed. I did not fall off the edge and I put that down to 52 weeks a year of rugby and cricket and the camaraderie of my teammates, plus a job in advertising that I loved. I became a workaholic, which is the brain's way of coping with the crap that is in there. I have always been a two-pot screamer so booze was never a problem. Being heavily involved in sport meant that drugs were out of the question.

When you have PTSD, you think that you are okay and that it is the rest of the world that is out of sync. As I said, I just thought I was jinxed. I was finally diagnosed in 2008, after being a guest of Defence cricket when I was at my lowest ebb. I received a DVA pension and a gold card. When I was recuperating from surgery for some old cricketing injuries, I had a lot more time to think. I wanted to do something to help others, but I did not know what. I did a lot of reading and a lot of research. The result of that was I founded the organisation Stand Tall for PTS and gained a former chief of the Defence Force, Sir Angus Houston, as my patron. Since then I have gained a pretty good list of other supporters, including another former Defence chief and now Governor-General, David Hurley, and West Australian governor, Kim Beazley.

At first, I concentrated on Vietnam veterans but the more I looked into the scale of the problems, they just grew and grew. How could I work with the military and veterans and ignore the first responders in emergency services? And there are others: victims of crime, accidents and domestic violence. Events last week, here and over the border, remind us that natural disasters can cause and trigger PTSD. Right now we see a war in Europe that is delivering—with 100 per cent certainty—many more people who will have a lifetime of PTSD amongst the military, civilians and those who go to help. This illness is the same, even though the causes vary. Neither myself as a layperson in charge of a totally volunteer not-for-profit nor Stand Tall are qualified to treat or advise treatment. Our task is to raise awareness and dissipate the stigma by talking to the authorities and decision-makers, like all of you who sit on this committee.

In 2015, I staged a major international PTSD and mental trauma conference here in Brisbane called PTS15. A second conference followed two years later, PTS17. When I spoke at the 2017 conference, I said that members and ex-members of the military, like me, were lucky to have the Department of Veterans' Affairs when we crashed and burned. The DVA is not perfect—far from it—but the coppers, firies, ambos and others who get sent out daily by state governments and risk acquiring PTSD have nothing like that. By definition, their jobs are needed because something has gone wrong, often tragically. They can experience all sorts of horrific events, yet they have nothing like DVA when they crash and burn. We can and must do more to help people and point them in the right direction to get help before it is too late.

I was interested to read a line in the committee's terms of reference. Point 1 says that you will consider the mental health needs of people at greater risk of poor mental health. In Australia, we have civilian control of the military. Our servicemen and women go into places and undertake tasks designed by the federal government. Our first responders work at the direction of the state governments. All of them are at risk of PTSD because their jobs increase that risk. That means governments must take responsibility for addressing the impacts on their employees.

In the case of first responders, in recent months I have started to engage with Queensland state MPs of all parties because this is a nonpartisan effort. I intend to become more proactive in 2022 and will keep knocking on any doors I can. In 2019, I started work on a totally results-oriented forum, but events, including COVID, pushed it back until March 24 and 25, 2022 to be held at the Brisbane Convention Centre. We have gathered the best of the best from around the world to talk about three big elements: transition, suicide and models of care. In every one of those areas, we must do better. The PTS22 concept is to come up with a series of irrefutable recommendations to present to the federal and state authorities.

I like to think that Stand Tall for PTS has grown from a naive little unit to what is now arguably the most prominent, totally volunteer entity in this space. I did not think when I started it that I would have the Governor-General as one of our biggest proactive supporters, who is both willing and eager to open our conference and follow its outcomes. As I said before, I cannot offer a therapy or treatment, but I can and will keep advocating for changes and building networks that can deliver those things and make a difference in people's lives as well as save lives.

I will send invitations to you all to attend PTS22 if you can, either in person or virtually. I offer my also services to the committee if you wish me to help make contact with any of the expert presenters at PTS22 to tap into their knowledge and ideas as you continue your work and draft your recommendations. I am willing to answer any questions you have of my personal experience and that of Stand Tall for PTS. Thank you again for this opportunity.

CHAIR: Thank you, Tony.

Mr Dell: As a layperson, I listened to the speakers before me and they amaze me with their medical knowledge. I do not have that.

CHAIR: I am lining up to do some study in the PTSD space at the moment; I have to write a research proposal. There seems to be a lot of understanding out there around the various treatment options and the relative outcomes, but there does not seem to be a huge amount of research around what works well in what situations and when. The way I describe it from what I have read so far is that we use the one tool for every job, basically. You described a whole range of different things that can traumatise somebody, but the types of trauma that people experience can mean that they need different types of treatment. At the moment it seems that we are very much in our infancy in terms of how we treat somebody who has developed PTSD.

Mr Dell: Yes, but it has been around since the Greek wars and we still do not have a real handle on it. For every 10 or 15 persons with some degree of PTSD, there could be 10 or 15 different avenues of recovery. I am of the understanding that it can never be cured. As Dr Andrew Khoo at the Toowong Private Hospital has said, ‘If I could repair brain, I could fix PTSD.’ It can only be managed.

The federal government will fund psychological and psychiatric help, but there is a whole range of other avenues that get no funding and, like me, are constantly trying to get grants, raise funds or have fundraising events just to keep our heads above water. For instance, canine therapy works a treat, but people who train those dogs and help those people struggle to get funding. Then there is equine therapy. There is an organisation called Mates4Mates that is funded by the Queensland RSL. They cannot get funding to do what they do and they do a damn good job. Very much part of their therapy is exercise. I go to the gym five days a week, mainly to fix my titanium knees and my titanium shoulder, but it works wonderfully well for me. I am 76 going on 77, and possibly I am in a better mental and physical state than I have been for a long time. There are just so many avenues of help.

If we look at the problems with government funding, why are there over 3,000 not-for-profits in this area? They are not getting the government help that they need, so people just decide, ‘Well, I have to do it myself.’

CHAIR: I would be interested in what you might know anecdotally around the experiences of PTSD in terms of engaging with existing mental health services if they get sick enough to end up in hospital, what those experiences are like, whether there is a good level of knowledge around PTSD and a good understanding of treatment options et cetera.

Mr Dell: Can you repeat the question?

CHAIR: I am interested in your understanding, based on your experience—and you obviously interact with a lot of people who have PTSD—around what people’s experiences are if they actually end up in mental health services.

Mr Dell: I do not think that they do. It is different from what the people before were speaking about. You will find that the majority of people are military veterans and first responders, as Melissa will tell you. You tend to think that PTSD or mental trauma is a weakness and you tend not to own up. There is this stigma attached to it where many people see it as a barrier to promotion, so they do not speak up. There was—I cannot remember his name now—a major general who was commander of the Australian forces in Afghanistan. He worked through PTSD while he commanded all of our troops in Afghanistan. He wrote a book titled, *Exit Wounds*—can you remember his name?

Mrs McMAHON: Not off the top of my head.

Mr Dell: I was in a meeting with Angus Houston, who was his boss at the time and also the Chief of Army then. Quite frankly, they were angry at him because (a) they did not recognise he had PTSD and (b) he did not tell them. At the highest echelon in the military, there is a person who will not admit that he has a problem.

One of my main reasons for being here is, as I said in this submission, we have DVA and they have their problems. I am in the royal commission as a result of that at present. It saddens me that state governments can send police, ambulance and firies out there to mop up all sorts of terrible situations and when they crash and burn, as they say, there is not a lot for them. I am told that if someone does fall by the wayside, they might put them behind a desk for 12 months. If they have not improved by then, they are sent on their way. From my knowledge, they have to fend for themselves.

We have this conference happening on 24 to 25 March. I have ex-police making presentations on transition. There is a lady who worked in the NSW Police force for 12 years and she has written a very good piece on transitioning out of the police force. The three main subjects that we are looking at are transition, suicide and models of care. In regard to models of care, we do not do it well. They are all interrelated: transition might lead to suicide and poor models of care might lead to suicide as well. That is what I am about.

CHAIR: We would be very interested in any information that could be supplied at that conference around models of care.

Mrs McMAHON: Thank you, Tony, for coming and telling your story. Notwithstanding some people's varying degrees of experience with the DVA, you suggested that here in Queensland we should have a similar organisation that specifically cares for our first responders. Under legislation and workplace health and safety, we do now have a consolidated list of first responders for whom PTSD and similar diagnosis is quite prevalent. Do you propose that the state government should consider implementing or establishing a similar authority for state based workers?

Mr Dell: That is what I would like to see, yes. As I said before, they leave the job and they are out on their own. To my knowledge, there is not a lot of help from their former employers to help them get through what happens to them. It would probably cost an absolute bomb, and that is probably the main reason why it does not happen, but it is something that I would like to see.

Dr ROWAN: Thank you, Tony. I know on behalf of all the members of the committee, I thank you for your service to our nation when you were in Vietnam.

Mr Dell: I did not have a choice.

Dr ROWAN: I know, but I would like to acknowledge that because certainly that was a contribution to our nation. I was in the Northern Territory earlier this year, in a health capacity. On the TV there were some ads about Standing Tall for PTS. Is that related to your organisation? Those ads were pretty powerful in identifying to the public the issue of PTS amongst first responders.

Mr Dell: As I said, I went 40 years without knowing what I had. I had no psychological or psychiatric help. I came back and I played a high level of cricket and I played a lot of rugby not long after I came back. For 52 weeks of the year, I was engaged in sport and had the camaraderie of my teammates et cetera, and I had a job that I loved. I worked from dawn to dusk. This was in advertising, before the digital days, when it was very much hands-on. I am sure that that is what got me through it.

I was in hospital after I was diagnosed, having my second knee replacement. I had been down to Canberra for the International Defence Cricket Challenge in 2009 and I had given a speech to the awards dinner and spoke about what I discovered with PTSD. I got a standing ovation from about 500 international defence cricket people. Then I came back to the Sunshine Coast, had my second knee replacement and, as I lay in hospital, I thought about what I could do. I started up Stand Tall for PTS. It took a couple of years. I had about $80,000 worth of debt from the problems with the recession we had to have back in the nineties. I got some help from the ACA through the cricket hardship fund. I had $40,000 worth of fines from the ATO. I had a pile of envelopes that high unopened because I knew there was bad news in it. I did not know why, but that is just what I did.

I founded Stand Tall for PTS in 2010. It was a very slow start. I went to DVA to see if I could get some funding and I just got the feeling that these people were saying, 'Who is this intruder into our territory?' They did not want to help me and the Queensland RSL did not want to help me, so it was a very slow start. I probably spent $70,000 to $80,000 of my pension money just to keep it afloat because it is what is in your head that drives you and keeps you going; you will not let go.

Then I sat down with Angus Houston in about 2014 and we decided that we needed to collaborate because there were so many different organisations wanting to get funding and we were all competing. We decided that it would be best if we could collaborate. The line for the conference was, 'Seeking Solutions Together'. Just before that, I decided that we needed to create more awareness so we made those television commercials in 2015, pro bono. All the creative work that we have done has been people coming on board, realising that this is a problem and wanting to help. Those commercials started to go to air in 2015 and they are still running. It is the media that is realising that, 'Okay, there is a problem out there. Let's keep these running to help.'

Dr ROWAN: The advertisements running in the Northern Territory are very powerful ads. Why are they not running in Queensland or other states?

Mr Dell: They went national. People in Longreach and Mount Isa have told me that they have seen them. I get phone calls from around Australia saying, 'Thank you, thank you, thank you.' We now have a second raft of commercials. I am not sure which one you actually saw. We did one for police, one for firies, one for ambos and one for military. Now we have this other campaign running which we call ‘Open Up’. We have decided that we need to be more proactive. We have created a song and another couple of commercials that ask people to recognise that they do have a problem and to start talking about it. That is the universal way of a first step forward to some sort of management of the problems that you have. By the end of 2022, with the media that we have in place and with the help of the media, it will be about a $5 million campaign, completely free of charge to us.

Dr ROWAN: There is no government funding to help run those ads, is there?

Mr Dell: No. I mean, good luck with that.

Dr ROWAN: Yes. Thank you, Chair.

CHAIR: Well, you never know your luck.

Mr Dell: I have been to the state government. I could get some funding if I wanted to put a plaque together or create a memorial garden of some description, but to actually help the people who are hurting there is nothing.

CHAIR: Tony, I would like to thank you for coming in and presenting this afternoon. I would like to thank you for the work you do as part of Stand Tall for PTS. It is certainly a very significant problem in our community and not just, as you say, for ex-service people but for a whole range of people. I think our knowledge and understanding of PTS is very much in its infancy and will be greatly improved thanks to the work of people such as yourself. Thank you for coming in. It certainly has helped us to understand this issue a bit better in the context of the committee’s report and recommendations as we go forward.

Mr Dell: Thank you.

The committee adjourned at 4.48 pm.