# *MENTAL HEALTH SELECT COMMITTEE*

**Members present:**
Mr JP Kelly MP—Chair
Ms AJ Camm MP
Mr RI Katter MP (virtual)
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—Inquiry Secretary
Ms M Westcott—Assistant Committee Secretary

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

## TRANSCRIPT OF PROCEEDINGS

**THURSDAY, 17 FEBRUARY 2022**

**Brisbane**

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**The committee met at 9.00 am.**

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

I would like to introduce the members of the committee. I am Joe Kelly, the member for Greenslopes and chair of the committee. Mr Rob Molhoek, the member for Southport, is the deputy chair. The other committee members are: Dr Christian Rowan, the member for Moggill; Ms Ali King, the member for Pumicestone; Mrs Melissa McMahon, the member for Macalister; Mr Barry O'Rourke, the member for Rockhampton; Ms Amanda Camm, the member for Whitsunday; and Mr Robbie Katter, the Member for Traeger, who is joining us today via videoconference.

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

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 direction at all times. You may be filmed or photographed during the proceedings and images may also appear on the parliament's website or social media pages. Please turn your mobile phones off or switch to silent mode.

I remind everyone that face masks are to be worn at all times. Witnesses and committee members may only remove their mask to speak during the proceedings. I retain the right to leave my mask off because I may have to speak at any time unexpectedly.

**ALLAN, Associate Professor John, Executive Director, Queensland Health**

**ALLEN, Mr Leon, Under Treasurer, Queensland Treasury**

**DRUMMOND, Mr Shaun, Chief Operating Officer, Queensland Health**

**FRKOVIC, Mr Ivan, Commissioner, Queensland Mental Health Commission**

**MOLLOY, Mr Dennis, Acting Deputy Under Treasurer, Economics and Fiscal, Queensland Treasury**

**CHAIR:** I now welcome the Queensland Mental Health Commissioner and representatives from Queensland Health and Queensland Treasury. I invite each agency to make a very brief opening statement, after which committee members will pose questions to you.

**Mr Frkovic:** I start by acknowledging the traditional owners of the lands on which we meet and pay my respects to elders past, present and emerging. I thank the committee for this opportunity to discuss the important topic of mental health.

It is important to note that mental health and AOD funding is the responsibility of both the Commonwealth and state governments. Queensland's mental health expenditure is reported to be approximately $1.26 billion in 2019-20, which I understand has increased in the last financial year. This excludes Commonwealth funding for the Medical Benefits Schedule and Pharmaceutical Benefits Scheme but also the primary healthcare networks. Some 83 per cent of these funds support acute hospital services and community ambulatory services, whilst 10 per cent funds psychosocial community support services and also residential services. Despite this, Queensland's mental health system has been substantially underfunded over the last decade. In terms of per capita spending, we are currently at the bottom of the jurisdictional ladder.

While general spending on health has increased, there has been no corresponding increase in mental health expenditure. Alcohol and other drugs services are also not well funded, with just 28 to 48 per cent of demand being met. This chronic underfunding has resulted in significant gaps within the mental health and AOD service system in Queensland, but this has been more recently compounded by the significant demand in services. Unfortunately, this translates to increased pressures on our emergency departments but also on our acute inpatient services.

Current investment, as I have articulated briefly to this committee previously, is primarily focused on supporting people at either end of the mental health spectrum—and we have discussed this. At the one end, services for mild to moderate conditions are mostly Commonwealth funded in the primary private health system and at the other end more acute, chronic and severe conditions are mostly supported by state funded public mental health services.

A lack of clarity between Commonwealth and state responsibilities means a substantial number of people are missing out. Their needs are too complex or severe for primary health care alone but not severe enough for the public mental health system. Estimates put this missing middle, as we are calling it, at approximately 150,000 Queenslanders who are currently not accessing services.

In the last decade the Commonwealth has increased its funding and scope. However, this has not always resulted in better access or better outcomes for consumers. There continue to be overlays, gaps and complexity in the patchwork system, services continue to operate in silos and poor integration ultimately leads to poor consumer outcomes.

The Commonwealth's initial Head to Health investment addressing the missing middle, which was announced last year, is welcome but nowhere near enough. If these centres are strongly integrated and co-located with other services such as our public mental health system, the non-government sector and the private sector, there are real opportunities to create a new community front door for mental health away from hospital.

To ensure best value for any new investment in mental health there must be a strong nexus between policy direction and funding. This must be underpinned by robust intergovernmental and cross-sector governance to effectively jointly plan and commission but also integrate services. Funding to support strategic policy directions is currently allocated in a disjointed manner, without consideration of the existing landscape or how leverage could be applied to make best use of our existing resources. Despite these challenges, Queensland has some excellent examples of joint planning and commissioning and mental health and AOD planning frameworks that need to be standardised and applied across the state and across the system.

In summary, while a sustained increase in funding is urgently needed, especially in the public mental health system, to target the missing middle and to support people who do not get an NDIS package, we also need to seriously invest upstream, in the areas of prevention and early intervention, if we are to stem the tide into acute hospital care, child safety, youth justice or corrections. The solution should also include reform to the way funds are allocated and spent including independent monitoring, review and public reporting of performance.

**Prof. Allan:** I respectfully acknowledge the traditional custodians of the land upon which this meeting is taking place, the Jagera and Turrbal people, and pay my respects to elders past, present and emerging. I also acknowledge people with a lived experience of mental illness, drug and alcohol and suicide issues and their families and carers. I am Associate Professor John Allan, the Executive Director of the Mental Health, Alcohol and Other Drugs Branch in the Department of Health. I thank the committee for the opportunity to return. I will highlight some issues from the Queensland Health submission, which builds on our previous briefing.

Over nearly three decades Queensland has been following the reform path set out in five successive national mental health plans, with a strong shift in the balance of investment from psychiatric hospitals to community-based service. For example, last year 70 per cent of service episodes through our public system occurred in the community. There has been a welcome shift in community-based beds, from none 10 years ago to 20 per cent of our beds being in the community now.

Queensland has experienced significant population growth. The total number of beds weighted by the population has not grown and there is a shortage of inpatient beds, particularly for acute admission. Between 2016 and 2021 the Queensland government invested more than $350 million into state funded specialist mental, alcohol and other drug services under Connecting Care to Recovery. Added to this significant funding boost were other important investments in action on ice, drugs and alcohol, suicide prevention crisis response, youth mental health rural support, community psychiatry, mental health community support, psychosocial services, various HHS capital programs and, most recently, the COVID response.

Despite this significant funding increase, the state funded mental health, alcohol and other drugs system in Queensland is under pressure. As Ivan has mentioned, demand for treatment is increasing at a faster rate than population growth and workforce increases. We have the lowest per capita expenditure and second lowest growth per capita expenditure in Australia on specialist mental health services and we have significant workforce constraints including the access to and the retention of a skilled and capable workforce across a range of mental health professions which is a constant challenge. There is a shortfall of mental health and alcohol and other drugs capital when compared to the need.

However, the people working in Queensland mental health, alcohol and drug services strive daily to provide a high standard of care in the context of significant capital and human shortfalls and challenges. Queensland has strong foundations with key system enablers in place to support future growth and development. These critical enablers include system and service planning, use of robust planning methodologies, capital planning, statewide and specialist services, a contemporary legislative framework for mental health, system and service improvement mechanisms and governance, partnerships and collaboration, including positive relationships at the HHS and primary health network level and an expanding lived experience workforce. The bulk of Queensland Health's submission focuses on the key enablers in areas of action where we can improve recovery focused care.

When I last appeared before the committee you asked me to name my three top priorities for investment. The submission contains many more than that, as you will see. However, I would say again: providing a crisis response in order that we save lives so people get on with what they should be doing; an early investment in young people to achieve their full potential—and this begins in infancy, otherwise we will never get there; recognising the health equity agenda for Aboriginal and Torres Strait Islander people is the way that we can improve the mental health, drug and alcohol issues for that group of people; and addressing the maldistribution of resources, especially for regional and remote Queenslanders where, as my colleague has highlighted, access is a significant problem. All of these remain high amongst the many other priorities.

The state funded mental health and alcohol and drugs system exists within a much broader system and should operate as a whole within a person centred framework to support the best outcomes for individuals, their families and carers. My colleague Mr Shaun Drummond and I look forward to answering your questions.

**Mr Allen:** Thank you to the chair and members for the opportunity to appear. Like my colleagues, we respectfully acknowledge the custodians and owners of the land on which we meet and pay respects to their elders past, present and emerging.

I would like to outline in our comments, maybe a little bit longer than we normally provide, a bit of context around the economic and social costs, some Queensland characteristics and impacts that might be important to the current debate and what we see as opportunities for reform in the future. I would also like to thank the committee for its consideration. I have to leave at 9.45. Deputy Under Treasurer Dennis Molloy will remain on the panel to answer any questions you may have.

In terms of the economic impact of mental illness in Queensland, significant impacts are incurred through lost economic and workforce participation and lost productivity. The Productivity Commission's 2020 inquiry on mental health provided some insight into these economic and social costs. We would like to provide a bit of an overlay of what the Queensland dimension of those numbers represent. They have conservatively estimated that an annual cost of mental ill health and suicide in 2018-19 was up to $70 billion nationally. This included $39 billion from lower economic participation and lost productivity, unemployment, absentee and reduced effectiveness at work. Queensland's share of that would be roughly $14 billion a year, including $8 billion in lower economic participation and lost productivity. In addition the estimated annual social cost—the emotional cost of disability and premature death to mental illness, suicide and self-inflicted injury—nationally was equivalent to a further $151 billion. Queensland's share of this would be approximately $30 billion.

Prior to the Productivity Commission report, CSIRO undertook a meta-analysis in 2017—a survey of other research and literature—and found that mental illness results in a greater chance of leaving school early, lower probability of gaining full-time employment and reduced quality of life. People with severe mental disorders represent a very vulnerable and socially excluded population more likely to be affected by lower educational and social opportunities, social alienation, increased morbidity and mortality. The Queensland context to that is worthwhile peeling back and having a look at. The Productivity Commission shows young people not in employment, education and training as well as our Aboriginal and Torres Strait Islander peoples face a higher risk of mental illness.

Since 2018 the proportion of young people not in employment, education and training has been trending downward, with the exception of 2020, which reflects the heightened impact of the COVID-19 pandemic.

The latest available data shows that this measure of youth disengagement fell to 10.2 per cent in 2021 from 15 per cent in 2020. Similarly, the youth unemployment rate has fallen from a pre-pandemic level of 14.6 per cent in 2020 to 11.1 per cent in 2021. That is while participation in the labour force has increased or improved over the period from 70 per cent to 75 per cent. Given the link between employment and mental health, this increased positive engagement for young people in employment would hopefully have some impact on the rates of mental illness in this cohort.

As of 2016, Queensland estimated Aboriginal and Torres Strait Islander peoples account for some 221,276 persons or 4.6 per cent of our total population. This is higher than an average nationally of 3.3 per cent. The Productivity Commission's insights on this are that regional and remote areas carry unique risk factors for mental health and mental illness, including isolation, and then the impacts of environmental events such as drought, which is particularly relevant to Queensland. A significant proportion of people live outside the greater capital city area, including Indigenous Queenslanders. Over half the population of Queensland resides outside of the Greater Brisbane area compared to, say, New South Wales, where the figure is 34 per cent and Victoria at 23 per cent. That obviously creates a different service delivery dimension in the Queensland context.

Since the Productivity Commission inquiry was undertaken, the COVID-19 pandemic has obviously had impacts on mental health which have been noted by my health colleagues. The longer term impacts are yet to be seen. Studies have shown that outbreaks and restrictions have been associated with the increased prevalence of psychological distress. Work experience has been impacted accordingly. It found that most people who have lost work experience worse mental health outcomes than those in steady employment. The strong employment outcomes associated with the health and economic response to COVID-19 in this state have been an important factor on mental health for Queenslanders. Fortunately, there has been a very strong jobs growth component to Queensland's performance compared to other states over this period.

We note that the number of jobs created in Queensland since March 2020 has increased to more than 106,000 in December 2021, noting that the Omicron outbreak may have some impact. We note though that in other jurisdictions this has led to different circumstances. They have had much more severe economic impacts. We have noted an increased focus on mental health nationally, but particularly in states such as Victoria which has announced a significant increase in its mental health funding. In terms of the opportunities I alluded to at the top—I will be winding up soon so thank you for the time—

**CHAIR:** We want to ask you some questions before you have to go!

**Mr Allen:** Yes. I think this accords with the analysis and measures undertaken by the Queensland Mental Health Commission in Shifting Minds: Queensland Mental Health Alcohol and Other Drugs Strategic Plan and what the Productivity Commission has put forward in terms of areas to focus on when it comes to reform. Early intervention and community care—and we heard the comment in relation to the shift out of hospital into community settings—are obviously areas we want to continue to focus on; providing the right service at the right time; creating alternatives to emergency departments for people with mental illness; and delivering mental health services effectively across government. I will conclude my remarks there.

**CHAIR:** Has Queensland Treasury assessed approaches to funding models for mental health services used in other states and considered their benefits?

**Mr Allen:** I note that in general budgeting for health is obviously a very challenging area for all governments given the demands on health. As a proportion of overall budgets, all states and territories in Australia are experiencing greater demand and greater investment in their health services. We have seen in association with COVID the investment into mental health services. In terms of our insights into those investments, we certainly review state budgets and see where money is being invested. I have alluded to Victoria. They have been the ones, from a funding perspective, if that is the question, that have certainly made a significant investment of some several billion dollars over the next four years in their last budget. The intention is to spend some $3.8 billion over four years on mental health. That has been matched with a mental health and wellbeing levy, which is a $2.9 billion measure that over the next four years will see that money earmarked for their mental health investment. That is probably the more significant funding measure I have seen in other jurisdictions.

**CHAIR:** Who are they are levying? To whom is the levy applied?

**Mr Allen:** The levy is a surcharge that is placed on payroll tax. The government of Victoria announced that that levy would be a surcharge paid by businesses with national payrolls over $10 million. Payroll tax is calculated by looking at the business's national payroll and then they pay that payroll on top of the employees engaged in Victoria. They have applied this surcharge to those businesses with national payrolls over $10 million. Then they apply an additional component to those businesses with national payrolls over $100 million. For a business below that $100 million threshold, they just pay the 0.5 per cent on top of their payroll. For those businesses with national payrolls over $100 million, they pay an additional 0.5 per cent on top of that.

**CHAIR:** In terms of opportunities you talked about the notion of cross-government work. The literature is pretty clear on the social determinants of mental health. It is pretty clear that investments in education, early childhood services, housing—even local government infrastructure—have a positive impact on mental health outcomes. Does Treasury incorporate this into the way it plans funding in terms of allocation of funds to housing and other services?

**Mr Allen:** The integration of budgets really is a matter that agencies need to collaborate on. They will include those components of their service need in the formulation of their budgets. That will be factored in on a portfolio basis to the extent that there are forums and interdepartmental mechanisms that look to the holistic approach and the very person-centred service outcome that agencies are trying to provide. It would be picked up at that level. You have a bottom-up information flow that goes into the calculation of the aggregate budget. In terms of its implementation, it is a matter of coordination amongst agencies in terms of how they deliver from a holistic perspective. In effect, that is the Holy Grail in terms of the ability to access multiple funding sources and deliver those in a coherent and coordinated fashion to those cohorts and individuals you are looking to positively influence.

**CHAIR:** In terms of the way the federal government provides funding around health care generally and also the significant changes we have seen in terms of the NDIS's introduction relatively recently, have you done any modelling on the impacts of the NDIS? How does the approach the federal government takes to funding healthcare service impact on mental health services? Are you in a position to answer that part of the question?

**Mr Allen:** I do not think I would be in terms of the detail you are seeking there. I can say that there has been work undertaken around the implementation of the NDIS by numerous bodies. On the productivity side, the Office of Productivity and Red Tape Reduction's concluding a report on that not too long ago. I refer to that being a slightly different model where we have seen a very decisive shift in terms of the accountability for those services to the Commonwealth. As perhaps alluded to by the Mental Health Commissioner, there is still a lack of clarity around roles and responsibilities when it comes to the mental health service area. I know that, through the current negotiations around the national agreement on mental health and suicide prevention, there is a real opportunity to try and clarify responsibilities and funding arrangements when it comes to the delivery of mental health services.

Treasury, through its role in intergovernmental relations, is aware of those moves and consideration of alternative funding arrangements such as joint commissioning with the objective of better outcomes for mental health illness. As I alluded to before, that involves the pooled funding. That would be between Commonwealth primary health networks and Queensland hospital and health services to provide care for patients who are currently falling between the gaps in the primary and acute healthcare sectors. That is really a great opportunity that I hope we can work with the Commonwealth on to deliver.

**CHAIR:** Do you see some real potential benefits in that joint commissioning model that was outlined in some of the other submissions, particularly from the PHNs?

**Mr Allen:** Yes.

**Dr ROWAN:** Given the outlining of how much it costs both the Australian community with respect to mental health and alcohol and other drug conditions and also the Queensland community—and that was outlined with the Productivity Commission's work—in terms of economic loss, the social, community and health costs and then the comments by the Mental Health Commissioner earlier about that strong nexus needed between policy and funding, could you outline why there appears to be a disconnect between what is allocated from Treasury and what is needed, given those direct costs but particularly those indirect costs as far as a loss of economic productivity, jobs and other things? Queensland is the lowest funded jurisdiction when compared with other state jurisdictions in terms of how much is allocated per capita for those services and yet it seems to be known by Treasury, 'Well, we have all of these direct costs but all of these indirect costs as well.' Why is there a disconnect among the evidence base, the policy and what is needed but what is funded?

**Mr Allen:** I probably would highlight that that is a conundrum amongst many areas of public policy. It is about the task of taking aggregate funding and then allocating it to relevant priorities, seeing where there is the opportunity for maximising outcomes and, in that case, the process of improving economic and social performance. Maybe I could provide a bit too much of the Treasury answer on the funding in terms of interstate comparisons. I will note in the first instance and then will reflect back on your question a bit further. In terms of the historical performance of Queensland having one of the lowest per capita expenditures of mental health services and being below the national average, I note that we are roughly in line with our peers in terms of New South Wales and Victoria. In terms of our per capita recurrent expenditure on state and territory specialised mental health services in 2019-20, Queensland on a per capita basis was $247.21 and New South Wales was $247.33. It is not a demonstrable difference on a per capita basis. Victoria is slightly above that at $248. I just wanted to point out that in terms of relativity we are not talking about a vast gap on a per capita basis. You can certainly look at other measures. I appreciate that they may reveal slightly different things. If you apply a higher population dollar it is going to be different as well.

I would say that there is a genuine understanding of shifting focus on to the preventative side of mental health while maintaining all of the acute services that go with having to ensure you are trying to maximise outcomes and look after the most vulnerable and those experiencing mental health issues. The reason I was highlighting employment outcomes and focusing on youth and ATSI populations is trying to steer as much as we can into those areas so we can take advantage. Unfortunately, right at the time we have a national discussion around this is when we have seen the demand for services escalate, and that just presents a higher order challenge for us. I do not think there is any lack of understanding of the economic and social opportunities; it is trying to balance the ultimately limited amount of resources into those areas of highest priority. There is a genuine interest to try and maximise and leverage the outcome, particularly when it comes to Commonwealth funding. If there is a genuine appetite to see additional dollars flow through, let us see if we cannot also utilise that as an opportunity to change the funding arrangements, clarify roles and responsibilities, and try and maximise some outcomes.

**Ms CAMM:** I have a question to the Under Treasurer that follows on from that. I am happy if you take it on notice. Is there data on that per capita spend? When we compare ourselves to Victoria, I think everyone agrees it is a centralised health model so it is very different to the reality of Queensland, which is a decentralised state. Can you break down that per capita spend based upon SEQ numbers versus per capita in rural, regional and remote areas? Comparatively and anecdotally one could surmise that the level of investment is not the same, it is not adequate and the accessibility that investment presents translates very differently. If you say it is $247.21 per capita, I think people in Mount Isa and other parts of Queensland, particularly in our Indigenous communities, would argue that. Do you have access to data that can be interrogated further? The second part of my question is not just at a state level, but at an intergovernmental level with the federal investment in primary healthcare networks, can you break down that data into rural, regional and remote areas?

**Mr Allen:** I would be more than happy to work with my Health colleagues, who may have already broken down that information. It is certainly something we can look to respond to and provide you with as much insight as we can. I would note—I think it was touched on by the Mental Health Commissioner—that there are no doubt challenges in delivering services into those locations. That would hopefully be something that can be worked on in terms of strategies going forward. There is a level of complexity that goes with the delivery of these services once you move away from dense areas. Just to pick up on the chair's comment around the NDIS, that has certainly been a real insight from the implementation of the new service delivery model for NDIS, where the absence, for want of a better term, of markets where we see a deep number of providers available is very different once you get away from the higher metropolitan areas. There are certainly challenges in delivering, and I would suggest that there is probably a disproportionate allocation of funding to meet that additional cost in those areas, but I would have to work with colleagues to get some of that information for you.

**Ms CAMM:** That was the second part to my question. We recognise that in regional and rural areas it is very hard to attract and retain certain speciality services, so I agree with you that a cost analysis is equally important to provide those services. That leads to potential recommendations of new ways in which we can deliver services et cetera. As a regional MP—and I know for my colleague in Mount Isa and others—it is important to understand where the baseline sits, particularly when we talk about policy, and maybe looking at introducing a levy or something where potentially a disadvantage already exists based upon equity, access and investment levels.

**CHAIR:** Just before you answer that, you took the previous question on notice; is that correct?

**Mr Allen:** Yes.

**CHAIR:** Thank you.

**Mr MOLHOEK:** I have seen data that talked about an efficiency score or the ability to measure the efficiency of mental health services and health systems. From what I understand, the Victorian health system operates at a higher level of efficiency because it is such a small state and there is a greater concentration of population. Following on from the member for Whitsunday's question, has there been any analysis or is there a way we can get a better understanding of the broader efficiency of the Queensland Health service as it compares elsewhere and the things that weigh into that? For example, we have so many small remote hospitals that have a base level of staffing where they have to be open 24/7, but they often have occasions where there will be either very few or no patients in the hospital at all.

**CHAIR:** We might go to Mr Drummond; it seems like he wants to answer that question.

**Mr Drummond:** Yes, we can do comparisons on that. In fact, the Queensland public health system is the second most efficient in cost by how we measure it, in weighted activity units, and what we spend in the block-funded areas of what we do. When you consider that in light of Victoria, which is the most efficient with a centralised system and not a decentralised state, we perform exceptionally well. That is credit to all of the clinicians and components of the system around how well they are performing. When you do look at the per capita spend you also have to overlay that we have an efficient system. If we are running an efficient system then our per capita spend should be slightly lower.

**Mr MOLHOEK:** Is there some international standard or universal score that is used?

**Mr Drummond:** The problem with that is that no jurisdiction is the same in terms of how they are funded, the components of the systems and where the responsibility lies with those components of the system. It is the end-to-end cost for providing wellbeing for that member of the community that really tells the story. There is no exact same system anywhere. We have like systems we compare to, and we do compare quite favourably with those. In terms of the states' investment in health, Australia compares very positively to First World countries.

**CHAIR:** Having said that, the discipline of health economics is relatively advanced in terms of assessing various health options; is that fair to say?

**Mr Drummond:** Yes.

**Ms KING:** My question is to the Under Treasurer. Throughout this inquiry and another I am involved with we have heard consistent reference to this issue of the missing middle, in particular in relation to prevention and early intervention. I take it that at least some services that would be delivered as part of a missing middle would fill that space of early intervention in particular, if not prevention. Can you please comment on what funding barriers there are that prevent the Queensland government from stepping into that space.

**Mr Allen:** Specifically in terms of barriers to any funding decision there will always be some consideration of respective roles and responsibilities. I think that is why we have heard reference to those roles and responsibilities and funding tasks that respective governments have. You would have to note that, if you are moving away from those acute service delivery options that are primarily with the states, then you start to lean into more of the primary services. That is not ignoring that there is a community service space as well that starts to become that sort of grey area, so the barrier in that sense is the ability to acquit and account for the expenditure of public moneys back to your respective authority while also trying to provide combined or pooled outcomes for individuals who are not really necessarily concerned about what level of government they are dealing with, so the handoffs between service providers become really important. Then it is the ability to understand that, if there are shifts in the form of care or the mode of care out of acute into something that is more community based or primary based, how significant is that shift and understanding whether there is indeed a change to the funding arrangements that would be important to drive further change in a particular area. That is all about your feedback loops back through the agencies that are there on the ground delivering those services. I hope I have answered some of your question.

**Ms KING:** I do not think I necessarily expressed myself very clearly. I suppose part of what I am asking about is what we know about the impact of insufficient primary care on the broader system and how those negotiations to better define roles and responsibilities are going, if you see significant change or opportunity for significant change, what that might look like, general comments.

**Mr Allen:** The key area of focus in my mind—and it may be broader and more sophisticated with my Health colleagues—is the extent to which we have emergency departments that are dealing with primary healthcare needs. That is not what emergency departments were set up for. If we have too many people who really should be looked after in different settings and we have not designed a system to provide the opportunity for them to gain services outside of an emergency department

setting, we are necessarily overpaying for the provision of services to those people. That is not really a good use of public moneys. We do not control that primary health system. That is really a big area nationally, but particularly for Queensland, where I would really like to see some outcomes achieved.

**Ms KING:** Would it be fair to say that the system as it stands is creating perverse incentives for consumers to seek their care in the wrong place?

**Mr Allen:** I think there are always opportunities for us to do better in that regard. In our case, we are talking about mental health patients who are being treated in acute hospital settings. When we know there is an opportunity to either work on greater early intervention or provide different service provision arrangements for those people, then we have a great opportunity to improve efficiency as well as improving outcomes.

**CHAIR:** It is also probably fair to say that, if you look at it from a GP's perspective, trying to manage complex mental health issues within the six minutes allocated is probably another example of system inefficiency.

I have one final question. The former mental health commissioner, in the submission that she made to the committee, referred to funding models used in Western Australia that promote greater accountability for service outcomes. Is Treasury aware of that approach, and has it been assessed and considered for opportunities to apply in Queensland?

**Mr Allen:** I am aware of, but do not have the detail, around that model. I would be happy to provide the committee with some information around that, if that would assist.

**CHAIR:** Yes, it would. We will get to you take that on notice, unless Queensland Health or the Mental Health Commissioner have any knowledge of that?

**Mr Frkovic:** The primary shift in Western Australia is around the mental health commission holding all of the funding. The mental health commission purchases from health, but it also purchases from the non-government sector. The advantage for Western Australia is that they only have three sub PHNs but one PHN. They seem to work really well between that one PHN and the commission in that joint commissioning discussion you mentioned earlier. They can purchase services in a different way and the accountability mechanism is different than what we have in Queensland.

**CHAIR:** I note that the Under Treasurer probably needs to leave us, so unless the member for Traeger has any specific questions for the Under Treasurer we might let him leave.

**Mr KATTER:** I have a question not for the Under Treasurer but we still have questions for this panel.

**CHAIR:** Would you like to lead off with the question.

**Mr KATTER:** I have been canvassing contributions in my area and I am probably acutely focused on the remote services. I have a view that we are chronically underserviced in the areas of mental health in remote areas. I know there is effort being made to try to resolve that and a lot of people are working to try to encourage students and new graduates to come and work in rural and remote health. It is a systemic issue; no matter what the professional trade, people are hugging the coast and the metropolitan areas and it is harder to bring those services out. I listened to the questions asked by the member for Whitsunday. Building on that but cutting through right to the base of this issue, we are talking about trying to get people to provide these services in remote areas. Granted there are strategies and efforts in place now, but I think it is fair to say there is, for want of a better term, market failure; what is there is just not working. I think part of the answer is to try to get those people earlier, but it would take more regulation in terms of students spending time in the rural area so they can see the benefits of working in areas like Mount Isa. Has some work been done there or is it acknowledged that there needs to be a lot of work in that space to encourage these professional health services to go out there? I am aware of what is there now, but it is obviously not working. Is there something else there, or is there an acknowledgement that something else is needed?

**Prof. Allan:** When we talk about the economic spend in rural and remote areas, often that is dinted by the fact that that recruitment is difficult; people do not stay and when you lose somebody there is a long gap to fill, as you are rightly pointing out. If you look at our submission we have a full chapter on the rural and remote workforce and the appendix has a set of initiatives we would have which includes earlier recruitment, scholarships, wanting to attract people while they are at university. I think the big issue is not that people are not enthusiastic. I have spoken to a number of people who have gone out. They come to see me on their way there and then the disillusionment they feel when there is not enough supports, there is no relief cover and other people resign is really difficult. I have done this work myself for a very long time, and I know communities are very welcoming and try very

hard to help people, but there are adjustment issues that are beyond the health realm and some of those are around community attitudes and supports. We have tried to address that in the submission, and I will not go through all of that. There is a lot of detail. I fully appreciate what you have said about that. We must get the word out, but we must keep them. The issue is about keeping people, not just about getting them.

**Mr KATTER:** That is a good answer. Thank you.

**CHAIR:** With regard to the National Mental Health Service Planning Framework—and I assume you are all aware of that—how does Queensland Health view this methodology and how do you incorporate it into your planning and delivery of mental health services?

**Prof. Allan:** Again, as we have said in the submission and in the previous briefing, we use that quite a lot. Just on this rural and remote issue, I think I said last time there has been a new adjustment factor for rural and remote to try to take into account the difficulty for that and for First Nations people as well, so we have a new version of that. We consider that to be ideal. Obviously the planning framework gives us a set of parameters you should aspire to. To be honest with you, nobody is ever going to fund that to 100 per cent; it is a very large amount of money. Nobody has ever had that to test to see whether that 100 per cent would be perfection or not, so we do not know that answer.

We do look at it to try to make our arguments with Treasury, to have a rational basis for what we are doing but try to help us look at the service system, the components of the service system as they fit together and try to get the right balance of the service system. We think it is a very useful term. I would say it is a tool that gives us the boxes that we need to fill, but it does not tell us what to fill them with. The people, the shape of the services, the way that they are run, the interactions—it does not tell us how we are going to do the interaction between the PHN and us. It is agnostic about who the provider should be. We have to fill the boxes in with the service system, but it is a very good estimate of what is required. It does cover.

**CHAIR:** The situation that the member for Traeger has described is that effectively it will tell you what you need out there but not how to get it.

**Prof. Allan:** It tells us what we need. It has introduced a new element about rural beds and looking at how we would support those rural towns in different ways to the ways that we currently have. In the discussions we have had with people, they have been very excited about how to develop different models. We are really looking forward to that.

**CHAIR:** In his opening statement the Mental Health Commissioner said that funding for the overall health system is up, but funding for the mental health segment and AOD services has not increased. Is that a result of some sort of systems problem internally in Queensland Health or the HHSs that we are increasing funding but it is not being allocated to mental health and AOD services?

**Mr Drummond:** It is quite complex. Effectively what we are talking about is the assigned funding to mental health. That is not all of the spending that goes into the community or for mental health consumers. For example, when there is an increase in the spend inside emergency departments, that is reflected in an emergency department spend, not in a spend for the mental health service. If we think about the default that we are experiencing with disability and the NDIS, we are seeing significant numbers of patients stranded in the acute system that have complex, challenging behaviours, mental health diagnosis and other conditions. Often that will be represented in the spend in the acute system rather than in the mental health system, although it does appear there as well. Whenever there is a failure—and we might use the term market failure—or a delay in organising those supports that are actually in the market, often that spend shows up in the acute component that is general adult health or general adolescent health rather than specifically in mental health. In fact, our spend is up in the system above what is assigned purely to mental health services. In fact, all of that increase in the emergency departments is primarily showing up in the spend on our emergency departments.

**Dr ROWAN:** My question is to Associate Professor Allan. Thank you to you and your other Queensland Health colleagues for the detailed submission. What I took away from the Queensland Health submission was there is clearly increasing demand for mental health services and increasing population in Queensland, reduced workforce availability, inadequate bed numbers, reduced public funding allocated to mental health here in Queensland when compared with other jurisdictions and then there are the impacts of COVID on top of that over the past two years. The Royal Australian and New Zealand College of Psychiatrists has said Queensland is the lowest funded jurisdiction per capita for mental health care and that we need an injection of about $750 million. I would like to ask whether Queensland Health agrees with the college of psychiatrists that that $750 million injection is needed now? Also what indexed funded model is needed into the future over the next decade?

**Prof. Allan:** I will start and then hand to Shaun for some more detail. Obviously from my point of view of being a leader in this space, I am looking for an injection of funding; that is pretty clear. The quantum of that is going to be decided by other people, but I think we try to make the case that it is a large amount of money. The planning framework—when I was talking about that 100 per cent—would suggest about $900 million a year to get to 100 per cent of that planning framework. I appreciate that is not going to happen. That is just a step too far and that is something we would look at a 10- or 20-year ambitious plan to get there and hopefully the community would change and our attitudes to mental health and drug and alcohol would change and there would be other changes we would want to make. That is just the service system. That is not talking about the other things we talked about in terms of what happens in education and justice and so on. Yes, we are looking for that.

I have looked to the college submission. They used a slightly different methodology than the planning framework. They have looked on a percentage basis what the Victorian royal commission offered and multiplied that. I have talked with the people who wrote that submission and they have asked those questions. I could dispute the figures, but from a service point of view we do need a large investment. I will let Shaun talk about where we might go with that.

**Mr Drummond:** As I highlighted earlier, one of the things it does not take into account is a relative efficiency between—it is looking at a per capita spend. There are two complexities in that, as I said: the nature of our regional basis but also how efficient we are as a system. One of the things around those guidelines is that all dollars are not the same. No, I do not believe $750 million is the right amount because it has not taken into account some of our complexity or the spend that is occurring in our system that is not in the paradigm of a mental health service but is for a mental health and alcohol and other drug consumer and is occurring in the acute system. Part of this is the opportunity around how we reorientate that into a stronger model for the community because there is spend occurring elsewhere inside our system that we need to recognise and there is the opportunity on that.

It is a vicious circle for us though. The more effective we get in the acute system, the more likely we are to get activity coming to us. We used the example before of a GP. If you see a GP and you go off to a different site to get pathology and then somewhere else for imaging. If you go to an emergency department you can get all of those in one location and you are not waiting a day or two for an appointment. As we get more and more effective, if we are not matched with that integration and improvement and effectiveness in the other components, what we get is disproportionate growth that is attracted to us. That is where we have to do the joint commissioning that works with so many other partners.

If we took that $750 million and spent that, we are going to attract effectively activity beyond what that was intended for unless we lift the whole system. That includes us working with the Commonwealth. One of the big problems that we have with the Commonwealth funding is that it is capped. This year is going to be a problematic year for us because the Commonwealth is capping at an approximately 2½ per cent volume increase in terms of what their model will give us as a system. While they might be recognising some of the cost pressures from two years ago—because that is how the system works: cost pressures from two years ago cascades into what it pays today, so it does not have COVID costs in how that has been set. Then because we are capped at 6½ per cent the volume gets what is left after cost escalation. We are facing a significant pressure because if we lift as a state, we are already at the cap and so we are not going to get Commonwealth contribution if it is coming out of the cap. There has to be a reset of this not just at a state level but at a Commonwealth level to recognise this.

Then we go into the opportunities around how the funding models at the moment do not react well to what we would call bundling. The bundling is to look at all of the services that are going into a consumer or a member of the community and how we can effectively commission that. That is some of what Ivan was talking about. If we can bundle that together, we can put in that funding pool to get the right modality, the right location whether it is in a regional or rural area across that whole intervention for the patient. At the moment under our model we are funded primarily for the acute component. Unless we can bundle across that, we will never have that impact of lifting everybody. If one single component lifts, that is where the pressure is going to be attracted to. It creates a gravity to it. That is our challenge.

**Mrs McMAHON:** My question will follow on from that. We have been talking at the very macro level in terms of funding. We have heard from a number of submissions and people appearing before the committee in the last couple of weeks about case management and the government departments involved in managing vulnerable people being siloed in how they are treated. Noting the touch points

between disability, mental health, alcohol and drugs, child safety, police, there is a need for all those government agencies to work together to manage to provide a better outcome. However, when you have that many different government departments working together, funding becomes a little bit tricky.

Considering we understand that when we manage these cases well, there are savings from a whole range of government departments. When we manage a vulnerable person and get them into treatment and through the system as is intended, we increase workforce participation and we decrease the touch points with the criminal justice system. How do we capture the funding required—and in policing we call them 'case in place' models in terms of getting everyone around the table from all government departments to manage.

How do we fund a model that draws on multiple departments when there is a bottom line for a project or a program? How do we best capture that? How do we articulate the savings for each of those individual departments down the track if they can manage the case together now—and looking at the savings that will be a touchpoint later in the criminal justice system such as education and workforce participation? Then, there is someone who can best understand how we fund a program which draws on so many different departments.

**Prof. Allan:** I think you have hit the nail on the head. When you have an underfunded department and then you go into partnership with someone else, you are always looking to spend the other person's money—not your own. The first thing you learn is that if you can get them to spend their money on what you want, that is a win. It is a huge problem because that does not happen very often. You are pulling away from the core to do extended work and unless you have strong personalities, it breaks down. It would be useful—I would hand this to the funding boffins. There does need to be brokerage. There does need to be some pooled funding. There needs to be strong service agreements.

When you have a service agreement it is often hard to identify the real issue. I go to meetings and we all see things in different ways and have different priorities. It would be good to get those priorities right and to think about the long-term outcome rather than just the avoidance of cost. I meet with multiple agencies at the local and organisational level. People who do this work have incredible goodwill. They recognise it will make a systematic change and everybody wants to do it. Then we go away and say, 'What resource are we going to use?' We do not have anything in our back pocket because everything is completely used up. It would be good if there was some leeway. I have never before experienced that sort of leeway.

**Mr Frkovic:** Trying to bring people together to work as an independent central agency is complex, whether it is within the state government or working across levels of government. Within the state government component, if you think about it, it is the internal capacity and capability to partner effectively. Generally people and other agencies will say, 'It is hard to partner with Health. They are a big agency with lots of resources.' That is what you will hear when you are talking to someone from Child Safety or the department of communities. Getting collective resourcing so that people can then collectively increase their capacity and capability to respond to this is critical.

Historically what used to happen, particularly from a state government perspective, is that lots of agencies rather than establishing their own capability around mental health, expected Health to provide that. We have seen some examples of that. For example, the evolved teams in Child Safety. The money comes to Child Safety and they purchase services from Health. Even that has come to a hold and other agencies now, at least the ones I am working with, are saying, 'Maybe we need to develop our own capacity and capability around mental health because it is hard to rely on Health because they are under so much pressure and have a whole range of issues they need to attend to.' You are seeing a shift in how the system is starting to work together but develop their own capacity and capability.

When you look across government, it becomes more complex. As John said, you try to get the other service to pay more rather than the state, for example. The challenge with all of that is—and we have touched on this and discussed it as a group—how we co-commission and take responsibility collectively for a region in terms of what is required in mental health. As I said in my brief introduction, we have some good examples of that with some of the HHS and PHNs working well together. We need to build upon that so it is not just co-planning, it is co-commissioning—we put our dollars on the table and buy for that region what is required.

Finally, we need service integration—and I think it was mentioned by the Under Treasurer earlier—because people do not particularly care who funds it; people just want a service to be able to move on with their life. We have to see the system more holistically. To finish off on Shaun's point, if we continue to fund more of the same then we are going to continue to attract people to the public

mental health system because that is the service of last resort—emergency departments et cetera. What we need to do is try to leverage. The Commonwealth has to step up in this space, particularly around primary health care and that missing middle to be able to butt up against the acute system in Queensland and provide people that continuum of care and support. That is the critical aspect in achieving system change. A new front door is required. A new front door that is not ED, but a new front door that is a community front door.

**Mrs McMAHON:** I would assume that community front door is where you might have these other government departments, such as housing and education. The question then is, as Professor Allan said to the financial boffins: do we have examples within budgetary spending where funds are allocated to projects where there are multiple government departments all being funded to participate in these multi-agency projects? If we can deal with these adequately, we are going to reduce the need for acute care in the early intervention. Do we have successful funding models for projects across a variety of government departments, and are they successful?

**Mr Drummond:** There are some examples but they are very much at the small end of the scale on things that we have done together. For example, Health needs no convincing around the social determinants of health. It is absolutely committed to education and employment which leads to housing. We have seen significant expansion in things like school-based traineeships over the past few years, particularly for disadvantaged communities. It is the ability to take students in year 10 plus and bring them in. It is about the sustainability of the health workforce in the future to create pathways to certificate training and then pathways into university. Even if that does not result in a workforce for health, it is about those social determinant commitments.

We have worked closely with Education and Health around school-based traineeships. That has come from within the current allocations and that has determined where we have seen scale because it is as we have been able to free up effectively spend inside health services and with local schools and their commitments and TAFE through that. There is an absolute willingness to collaborate. I will make one comment that might sound cynical but it comes along with the comment that John made. What happens often, though, when Health comes to the table is that everybody says, 'You are by far the biggest budget of everybody—how can we spend your money?' That is whether we talk to NGOs, the Commonwealth or primary care. We often get people who look at it and say, 'You have got such a large budget, surely you can cover this?' The problem is we are finely tuned and for us to make strategic investments, it comes from crisis response today. There are longer term paybacks for making that investment. We are likely to see an impact.

School-based traineeships is a fabulous program. It is something I was committed to when I was a chief executive and with my role inside the department now. We will see that benefit in the community in five to six years. We are effectively spending money that is provided for care today to do that, which limits how much we can reorientate.

**Mr MOLHOEK:** I am not sure I want to open this can of worms. We have heard a lot of data and information from service providers here in Australia. Ivan, you have spoken on many occasions on the need for early intervention. Have we done any sort of comparisons on how mental health systems work and function in other parts of the world? How does Australia and Queensland compare with other nations in terms of practices and in respect of the overall health and wellbeing of our citizens? It is a big question.

**Mr Frkovic:** It is a big question.

**Mr MOLHOEK:** I raise it because I have heard people talk about or refer to mental health and domestic violence and drug and alcohol and all these other things as a 'disease of the west'—it is a consequence of too much affluence. I would be interested in your reflections around that.

**Mr Frkovic:** I am happy to talk at the systems level, but John might have some of his own experience. I have certainly visited a number of countries and looked at their mental health systems. One thing I walked away with was that no-one has a good system. I visited most of the western types of democracies. No-one has a really good system of care. People are still falling through a gap. There are pockets of excellence around the world, including in Queensland. We have some great pockets of excellence.

As I said in my initial introduction, we have some phenomenal pockets of excellence. It is how you systemise those things? For example, Trieste in Italy is probably the world exemplar when it comes to community care. It is cultural. In Trieste if my relative gets admitted to the acute hospital which has only got a number of beds that is a failure of the system. It is not like we see in Australia: 'I finally got my relative into a bed.' They see in situ support—in community, in-house et cetera—as the cultural driver; the values that drive how they want their support delivered. Trieste is seen as the

best. More recently they have experienced some challenges because the government is realising what they are doing in Trieste they cannot do for the rest of Italy so should we dismantle some of this? They are the world example.

I went to Sweden to look at the early years program. When you have a baby in Sweden you get 15 follow-ups, including with a maternity nurse. You get a social worker who looks at the context the child is growing up in, plus a GP. It is outreach assertive into your home but also centre-based depending on what you need. There is leave for parents, both males and females. They have made a considerable investment in the upstream because that produces a different outcome downstream.

**Mr MOLHOEK:** They have natural gas that they pipe out of the ground into Europe and the highest wealth per head of population in the world.

**Mr Frkovic:** They have money. Then, I went to Portugal to look at the drug and alcohol system and the concept of decriminalisation. Again, I can talk about this for a long time. They have made some major gains around how they are dealing with drugs and alcohol. Apart from the whole decriminalisation concept, one figure was really impressive. The rates of addiction amongst young people from when decriminalisation started, and continuing for the last 20 years, are on the way down. They have changed the way they interact with drugs and alcohol in the community. It has produced different outcomes for them, including reduced pressure on corrections, police and courts. Everybody has good elements but no-one has a systematic approach, apart from what I saw with drug and alcohol in Portugal. We are not Portugal. We are different to Portugal. There are elements and pockets in Canada, the US and across the ditch in New Zealand. Here in Queensland we are doing good things.

**Prof. Allan:** I think Ivan is pretty accurate. I will just add this: Ivan and I are both members of a group called the International Initiative for Mental Health Leadership, so where mental health leaders get together and compare and look at exemplars and try to teach each other. It has not met for a while because of COVID. There is a benchmarking group that I am a part of where we look at the data and we look at the comparisons. Most people admire our system. They look at the Australian system and think, 'You've got a lot of community psychiatry that we don't have.' We have invested in some parts in early psychosis, as Ivan has pointed out, and we seem to be leaders in some of those early childhood things as well. People look at that. I would say that the Scandinavians have a bigger spend and a better outcome and they spend more money. They treat people in more individual ways. For example, as Ivan said, if you get a psychosis in Denmark you get a guaranteed psychotherapist for two years to help you sort out your life. You carry that person with you wherever you go in terms of doing that. In Finland they give a priority to telemedicine for the people who live away and they give the best therapists to telemedicine because they recognise that people further away get that. There are lots of little things that they do.

Just in terms of your question, the Canadian system for promotion and public health measures in mental health is one that people admire. The UK has done a lot of work in that area as well but not as successfully. I think that the Holy Grail to find the right kind of early intervention and promotion and so on is around. New Zealand have looked at that and, again, there have been many fantastic wins in New Zealand—Shaun will speak about New Zealand—but just recently they are thinking that maybe they went too far and now they have lost the capacity in their hospitals and they have had to reorganise that. We have good bits. People admire our good bits. We punch above our weight worldwide but there are lots of things we could learn from. That is probably the best answer.

**Mr MOLHOEK:** Which is encouraging to hear. If you spend too many days doing this you could be mistaken for believing that things are pretty grim, and it is for people who are struggling with it, but it is pleasing to hear that we do better than many other parts of the world.

**CHAIR:** I want to spend some time on co-commissioning, particularly between HHSs and PHNs. It would be my understanding that Queensland Health does not control the day-to-day decisions of HHSs, that they make independent decisions around a whole range of things. It would seem to me that there is great capacity there for HHSs to engage with PHN's around a co-commissioning model if they choose to.

**Mr Drummond:** We do work in a network system. While they are independent in part, their funding and how we commission activity and the services from them is from the system manager, which is Queensland Health. We do commission. In terms of how we commission and the funding models, we do have control of the incentives around where we effectively can push the clinical services to to respond. We have the ability to do that, but then we do not manage that partnership between a PHN and a HHS and so that does depend on that local relationship and commitment around how they would commission together.

**CHAIR:** Do the seven PHNs line up with our HHSs?

**Mr Drummond:** Largely.

**CHAIR:** The Brisbane South PHN in their submission talked about some co-commissioning that has been happening in that area. I assume that has been driven locally through good relationships between the PHN and the HHS. Is that achieving outcomes in terms of starting to move towards dealing with the missing middle?

**Prof. Allan:** You might need to also ask Brisbane South PHN. I think there are two issues. One is, yes, it is trying to look at some of those joint issues and helping towards that missing middle. Some of that is local but there is also a planning framework. The PHNs and the HHSs have developed a joint mental health plan and that is part of a national initiative to have everyone have that plan and we have supported them with using the planning framework and so on. I think the issue is that, yes, they are good initiatives, but the amount of funding available to the PHN is quite small. Again you will need to ask them this, but my perception is that there are quite strict Commonwealth requirements about the way that they spend their money, and the flexible funds are small.

We are currently working with the Commonwealth on a bilateral negotiation agreement for joint funding, joint commissioning, of some services towards the missing middle, which we have talked about before and I can talk in more detail about, so that is moving that along and it would be good to see an increase in the funds, but again compared to what we have talked about and what you mention in the submission and so on, it is a small amount. It is a start of that work. Yes, there is that central control and we need that central direction, but there is also that local thing, but it is not a lot of money.

**CHAIR:** This question is directed probably more to the Mental Health Commissioner, but would we need to take a different approach in Indigenous and First Nations communities? For example, in a place like Cairns you have your Cairns HHS and I assume Yarrabah falls within that. It would seem to me that you would have to take a different approach in Yarrabah to what you might take in the rest of the HHS.

**Prof. Allan:** We work with the NACCHO in Yarrabah. We have funding agreements and joint commissioning now and drug and alcohol services and so on. In Cairns we have moved positions from Queensland Health into the Aboriginal controlled services because of the cultural context and that seems a better way to do things. I think that is a good pattern. It is one that we would need to develop. I know there has been work done in the metro areas in a similar way. I think that the Aboriginal controlled health organisations are as big a player in this field as the PHNs when you come to that.

**CHAIR:** Before I go to the member for Whitsunday, this co-commissioning, particularly let us look at Metro South, it involves, from what I can see, two key parties: the PHN and Metro South. To what extent is there the capacity then to move beyond those two parties to looking at the community sector or even the private sector around involvement in the planning and perhaps commissioning of services?

**Mr Frkovic:** I think there are great opportunities to do that and I agree with John. It has only occurred in a small program that was funded by the Commonwealth through Beyond Blue that came to the PHNs and then the state contributed to that and rather than commissioning individually for small amounts of money for the same program, which was the Way Back program from my recollection, the money was pooled locally. In fact, I think, if I am right, John, Queensland Health provided the funding to the PHN so that could be co-commissioned jointly for a small program to support people who present to ED with suicidal ideation and need that ongoing support. I think, Chair, your point is right, and I think there are some good learnings from that. Yes, it is small, but the opportunity in terms of doing co-commissioning, particularly going into the future I think is much greater as a result of some of the confidence that has been built up around that. But we need flexibility, picking up Shaun's point with the HHSs et cetera, to be able to do flexibility in funding particularly for the HHSs and, as John says, the Commonwealth to give the PHNs greater flexibility to be able to do joint funding and that will certainly help. The challenge will be what we do with existing funding that is not co-commissioned and do we think about what does that mean or do we just focus on future funding and looking at co-commissioning.

**CHAIR:** It sounds like it is one of these pockets of excellence that could become systemised.

**Mr Frkovic:** Yes.

**Ms CAMM:** My question is either to Mr Drummond or Professor Allan, but very much Queensland Health. In your submission you outline the need for cultural change, leadership, investment resourcing into that area and note also the HHSs. This follows on from the chair's question. When I travel the state and I speak with HHSs, both in South-West Queensland, North-West Queensland, North Queensland, Central Queensland, my own HHS, they report that there are challenges and barriers to that cultural change, that empowerment that exists. You have outlined that

there are still mechanisms of control, which may be rightly so in some areas, but when we talk about a community being able to be empowered to look at co-design models, to be able to engage fully with the PHN and the community sector where there may be a shortfall in resourcing or a constraint in budgets et cetera, do you see that there are existing barriers, particularly in the space of leadership and cultural change? I will give you an example. An example might be a person in a position of leadership within an HHS where they are in conflict of that culture or the direction and it is very challenging for the HHS to be empowered to make decisions around that, whether it be an individual position or program et cetera. That is what they are reporting back. I look forward to hearing from our HHSs as we travel around the state, but do you see from your positions that there are barriers and ways in which that culture and leadership could be improved across our state and, if so, what sort of resourcing would that require to help facilitate that co-design and empowerment at a place-based level?

**Mr Drummond:** There is not a system barrier from the centre that prevents a HHS from dealing and evolving in relation to its culture and its behaviours. We have about 117,000 people inside Queensland Health and with such a large workforce it is about locally what happens. The number of directives that we—

**Ms CAMM:** Could I interrupt and give you an example. An IR matter, where we have seen a performance management process go for over two years, legal fees in excess of $100,000 that has been taken away from patient care and a HHS has had to direct that into HR or IR challenges. That is what is being reported. When we talk about a system barrier, even down to whether it be a HR process or anything like that, you are saying there is no system barrier?

**Mr Drummond:** No, because they are managed at a local level. Unless the health service was conflicted with who might be the decision-makers, most things are managed at a local level. They are managed within a state framework around what our industrial relations obligations are, because we have enterprise agreements that set that, we have effectively contract law and case law around how we must behave, but that is managed at a local level.

**Ms CAMM:** Do you think they are adequately resourced to be able to manage that? At the moment, if we talk about culture and leadership change and the resourcing of our HHSs, you feel that they are adequately resourced to meet how they can change and be agile enough to respond to the mental health demands and the system and priorities that they have?

**Mr Drummond:** It is a local decision around how much they put into supporting that. The financial performance of hospital and health services varies.

**Ms CAMM:** Yes, but does the state set that? As Queensland Health, do you set that within that HHS or does the HHS sets that?

**Mr Drummond:** No, we do not and I will give you an example as an HHS chief executive, having previously been one. I would every year get one of the hospitals come to me to say, 'We've got the lowest ratio of clinical pharmacy between our peers inside the health service so can we have some extra money for that?', and I would be say, 'But wait a sec, you're paid at the same rate as everybody. There has been a local decision around your model of care and where the emphasis is that you have as an organisation', because in a large system we cannot micromanage all of those components and all of those splits. We do have an empowered system that allows people to make decisions. Are they always the decision we would make? No. That is a really clear example of where I would be sitting down and saying, 'Well, you need to do a peer challenge inside your hospital around why that distribution has been the most effective distribution for that.' As a centre, if we were trying to interfere in that we would have 150 hospitals where we were trying to set what would be the ratios of clinical pharmacy. That is a really simple example compared to what we do in cultural leadership and human resources, but again what we are not trying to do is to micromanage the individual elements of their business. What we are trying to do is to say, 'You are empowered. You need to figure out what your direction is in this within the overall framework of what we expect and what our obligations are.' There are individual investment decisions made at a health service level. As I say, when you come to the individual we would all make different priorities around what we think is most appropriate locally.

**Ms CAMM:** The question I asked is do you feel there needs to be better resourcing and funding to meet the demands that you have outlined in your submission that prioritises leadership and cultural change?

**Mr Drummond:** I think we can certainly do more investment in how we do leadership and cultural change, yes. That does not mean that we need a budget for doing that, that is about prioritisation of resources.

**CHAIR:** There have been a number of questions taken on notice today. If we could have your responses provided to the secretariat by the close of business on Friday, 25 February that would be greatly appreciated. Members of the committee may also have additional questions that they wish to put after today's session and the secretariat will supply those to you. I would like to thank all of you for making yourselves available this morning. It has been a most useful discussion. It has helped the committee to understand some of the issues around funding in relation to mental health and AOD services in Queensland.

**The committee adjourned at 10.30 am.**