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MENTAL HEALTH SELECT COMMITTEE

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

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

TRANSCRIPT OF PROCEEDINGS

THURSDAY, 20 JANUARY 2022

Brisbane

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THURSDAY, 20 JANUARY 2022

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The committee met at 9.30 am.

CHAIR: Good morning. I now declare this public briefing of the Mental Health Select Committee open. It is good to be here having our very first public briefing. I would like to respectfully acknowledge the traditional custodians of the land on which we meet today and pay our respects to eldest 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; Dr Christian Rowan, the member for Moggill; Ms Ali King, the member for Pumicestone; Mrs Melissa McMahon, the member for Macalister; and Mr Barry O'Rourke, the member for Rockhampton. Online via the phone today we have Ms Amanda Camm, the member for Whitsunday, and Mr Robbie Katter, the member for Traeger. The purpose of today's briefing with Queensland Health and the Queensland Mental Health Commissioner—I acknowledge the Commissioner as well—is to assist the committee in its inquiry into opportunities to improve mental health outcomes for Queenslanders, which is something I am sure we are all very committed to.

This briefing is a proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. Only committee members and invited witnesses may participate in the proceedings. Witnesses are not required to give evidence under oath or affirmation, but I remind witnesses that intentionally misleading the committee is a very serious offence. I remind committee members that officers are here to provide factual or technical information. Any questions seeking an opinion about policy should be directed to the minister or left to debate on the floor of parliament.

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 and images may also appear on the parliamentary website or social media pages. Please turn your mobile phones off or switch them to silent. I remind everyone that face masks are to be worn at all times. Witnesses and committee members may only remove their face mask to speak during the proceedings. As the chair, I shall have mine off at all times because I may need to speak at any particular time.

ALLAN, Associate Professor John, Executive Director, Mental Health Alcohol and Other Drugs Branch, Queensland Health

GARNER, Ms Sandra, Director, Mental Health Response Program, Queensland Ambulance Service, Queensland Health

McBRIDE, Ms Liza-Jane, Chief Allied Health Officer, Queensland Health

MILLER, Ms Deborah, Chief Nursing and Midwifery Officer, Queensland Health

REILLY, Dr John, Chief Psychiatrist, Queensland Health

CHAIR: I now welcome representatives from Queensland Health. I would like to invite witnesses to make a collective 10-minute opening statement. That can be one of you or you can all take a turn each, whichever way you choose to go, but the floor is yours for 10 minutes.

Prof. Allan: I respectfully acknowledge the traditional custodians of the land on which this meeting is taking place, the Jagera and Turrbal people, and pay respects to their elders past, present, and emerging.

I am Associate Professor John Allan, executive director of the Mental Health Alcohol and Other Drugs Branch, Department of Health. I thank the Committee for the opportunity to provide the following opening statement. Today I am going to concentrate on the treatment service system that is state-funded specialist treatment, care and support for individuals, their families and carers experiencing severe mental illness and/or problematic substance use and mental health crisis and

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suicidal distress. This care is delivered through Queensland Health's 16 hospital and health services—known as HHSs—non-government organisations, Aboriginal and Torres Strait Islander community controlled organisations, and the Queensland Ambulance Service. These services are critical for improving mental health outcomes for Queenslanders.

Delivery of this care takes place within a broader system that includes other public, private and non-government services and within a complex legislative, policy, planning, commissioning and funding environment. Treatment, care and support also takes place across a continuum of care, with population-based programs providing universal and targeted promotion, prevention and harm minimisation approaches down one end shifting across to primary health care through to specialised care. I refer you to diagram 2 in the Queensland Health written briefing which shows this continuum. The Department of Health—in particular the Mental Health Alcohol and Other Drugs Branch—provides system-wide clinical and policy advice and leadership to support safe, quality, evidence-based treatment, care and support. The Queensland Ambulance Service, as the legislated statewide provider of pre-hospital emergency health care, also has a critical role in responding to people, especially those experiencing a mental health crisis, including suicide crises.

Queensland has one of the lowest per capita expenditures on public specialised mental health services across Australian jurisdictions. Additionally, while there has been a growth of 62 per cent in per capita expenditure on public hospital and health services between 2009 and 2018-19 in Queensland, comparatively mental health per capita expenditure has only increased by 10 per cent during the same time period despite significant recent investment. In 2020-21, only nine per cent—approximately $139 million—of state-funded mental health, alcohol and other drugs expenditure was spent on alcohol and other drugs services delivered by HHSs and NGO service providers. We have strong foundations and mechanisms underpinning the state-funded mental health, alcohol and other drugs system in Queensland; however, demand for treatment and care through our HHSs, funded NGOs and community controlled organisations is greater than existing resourcing. Services are unable to meet existing need and keep up with this demand.

The COVID-19 pandemic has amplified issues being experienced across the health system. Referrals for mental health community treatment services increased by 12 per cent between 2019-20 and 2020-21, with referrals for adolescents—12- to 17-year-olds—increasing by approximately 20 per cent over this period. Presentations to emergency departments with a self-harm or suicide ideation diagnosis increased on average by 14 per cent each year between 2016-17 and 2020-21. There have been notable increases in people presenting with eating disorders. There were almost 400 more referrals for eating issues for persons aged 12-17—a 97 per cent increase to 806 referrals in 2020-21—for anxiety, alcohol and drug problems, and adult and child and youth services are reporting significant and unmet demand pressures. Additionally, each year the QAS has seen an increase in the number of people calling triple 0 in a mental health emergency to over 60,000 in 2021.

Every death by suicide is a tragedy. The average suicide death rate for all Queenslanders for the five-year period 2016-2020 was 15.4 deaths per 100,000 population—a small decrease from the previous period—but Queensland remains above the national average, which is 12.5 deaths per 100,000 population. At this time the anticipated increase in the suicide rate due to the pandemic has not eventuated.

Significant work has taken place over the last 10 to 15 years to reform and build Queensland's state-funded mental health, alcohol and other drugs service system. The evaluation of Queensland Health's most recent plan for state-funded mental health alcohol and other drugs services, Connecting Care to Recovery, showed the following gains made from 2016-2021: an increase in access to highly-specialised services; improved community bed-based and community ambulatory services to provide early access to treatment and care; improved individual experience and protection of rights due to an increased peer workforce, the creation of independent rights advisers, and a cultural shift towards greater inclusion of individuals, carers and lived experience advisors in care; improved systems, knowledge, and confidence within health services to identify and respond to suicide risk; enhanced integration of care for people through the integration of previously separate AOD and mental health clinical systems and improved access to data for service providers.

Of course, more needs to be done. Queensland Health is working to identify solutions and a longer-term investment framework to support ongoing service improvement, resolve existing gaps, and meet growth in demand. Queensland Health is working with partners across the healthcare network to build robust and responsive services which meet the needs of Queenslanders. The QAS Mental Health Co-Responder project is an example of this collaboration. A mental health clinician is paired with a QAS paramedic to respond to people in a mental health crisis. More than 65 per cent of the people seen by the QAS mental health co-responder teams are kept away from emergency

departments and the hospital system. To do this, we use key planning frameworks and tools and work in strong partnership with HHSs, people with a lived experience, PHNs and key peak representative organisations.

It is clear that additional investment is required. This needs to be appropriately distributed across the critical factors and mechanisms required for the delivery of contemporary and safe models of care with an optimal service mix. These factors include, in no particular order: clinical improvement and practice change; workforce development and expansion; digital information and technology infrastructure; built infrastructure supporting hospital and community bed-based and ambulatory models of care; policy, planning, funding, and commissioning; data, monitoring, evaluation, and research; and governance, safety and quality.

People with lived experience, our consumers and carers, have strong and deep individual and collective knowledge of their situation, circumstances, and the impacts of services on their lives. We are committed to engaging people with a lived experience and want to continue to build on this to enable and strengthen involvement across policy and planning, governance, monitoring and engagement of service delivery. For example, we have worked to re-establish a statewide peak body for mental health consumers, Mental Health Lived Experience Peak Queensland, which is now up and running.

We also need to contribute to efforts to ensure that health equity and cultural safety outcomes for Aboriginal and Torres Strait Islander peoples are achieved. Meeting health equity has been enshrined in legislation as a reflection of its significance and importance. While it is acknowledged that more reform and increased investment is required within the state-funded mental health, alcohol and other drugs system, our services will continue to struggle if other parts of the broader health and social system are not functioning optimally. I know that my colleague, the Mental Health Commissioner, will also address this.

Access to GPs and general support services, described as primary mental health care, in a stepped model of mental health care is critical. Without this early intervention and care coordination to assist individuals and their families we risk issues, crises and conditions worsening and escalating. Ongoing reform and increased investment and support for those parts of the health system which fall within the remit of the Commonwealth government and outside the purview of the Queensland government are required. This also includes the operation of the National Disability Insurance Scheme, which needs to be continually monitored and adapted and adequately funded to respond in an effective and fair manner to support Queenslanders experiencing psychosocial disability. Increasingly our HHSs' mental health, alcohol and other drugs services are having to respond to people where NDIS services are not available or have failed them.

Ongoing effort, investment and accountability across a broad range of social and human services, systems and sectors to address the socio-economic determinants of health and other life outcomes is also required. The broader reform approach requires all of us to work more effectively together with partners from across different levels of government and within and between health service sectors and social and human services to ensure we are able to holistically meet the needs of people experiencing severe mental illness, substance misuse and crisis.

Queensland Health's written briefing provides an overview of the state-funded mental health, alcohol and other drugs service system and crises responses and some of the challenges it is facing. In partnership with our HHSs and the QAS, we are preparing Queensland Health's submission to the committee. In that submission we will highlight what we believe is required to ensure a more robust state-funded mental health, alcohol and other drugs service system and response to crises. I would like to thank the committee for the opportunity to speak today and reassure the committee that Queensland Health is deeply committed to improving the mental health outcomes of Queenslanders.

CHAIR: The member for Traeger is unable to stay for the entire meeting today due to health issues, but I wanted to invite the member for Traeger, Mr Robbie Katter, to start with any questions.

Mr KATTER: I was not actually ready yet, Mr Chair. I do have a couple of questions, but can you come back to me?

CHAIR: Yes. Do you need to leave by 10 o'clock?

Mr KATTER: Yes, I was hoping to go by 10 o'clock.

CHAIR: I will ask a question and then we will come back to you, if that is okay. I will start off. Thank you for your submission; it was very fulsome. I will start at the beginning. You talked about population health and preventative health quite extensively in your submission. I know that Queensland Health has a really large role to play in terms of population and preventative health in

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relation to physical issues. I am also aware of the work they have done around things like smoking and some of the alcohol and drug services. How would you characterise the role of Queensland Health in relation to mental health when it comes to preventative health and population health?

002 **Prof. Allan:** Preventative health is a really important part of what we do. Obviously prevention leads to a decrease in services. I think it is probably fair to say that in recent years there has not been as much prevention in mental health as we should have had. The crisis in the service system means that a lot of funding has been directed towards that.

Perhaps this afternoon you will be able to talk more with my colleague the commissioner about that because the commission does have a role in promotion and prevention. It has had a number of really good initiatives. For example, some of the awareness campaigns that have been run by the commission have been quite good, but they are run on a shoestring as well and we need to acknowledge that.

I think that throughout the country there has been an issue around promotion and prevention of mental health. We have had some good organisations. We often rely upon national campaigns like those run by Beyond Blue or the Black Dog Institute and so on. I think there has been a lot of work particularly around the issues of suicide prevention. We do try to address that because that is obviously very much an early intervention piece. It is certainly true that we could have more investment in that.

CHAIR: It is certainly fair to say that there could be a much greater role for Queensland Health in terms of population health and preventative health strategies.

Prof. Allan: Yes.

CHAIR: Member for Traeger, are you ready to ask your question?

Mr KATTER: My question is around gaps particularly in remote areas—and we know there are. Notably in the North West HHS there is talk about simple things like having safety rooms or whatever they are called—the fact that when someone presents who has acute mental health issues they do not have a room to put them in. That is an obvious deficit in services or infrastructure. Are those deficits fairly well identified throughout the network?

Prof. Allan: Yes, it is identified. When we give our submission we will talk in more detail about some of those gaps in rural services. I will make a couple of points. One is that the National Mental Health Service Planning Framework—which is a planning tool that we use, and we will talk about that in much more detail in the findings of our submission—has been recently revised to try to address some of those gaps in rural services, noting that there needs to be loading for rural services. It does do that.

It has also introduced a new class of beds which are rural beds to point out the fact that there might not be a population that would support a large inpatient unit, but there is a need to have some kind of service that addresses what the member is talking about—for crisis support or support pods or some beds. We would be advocating for those in that work.

I think it is really important to note that gaps in rural services are not just in our services but they are also particularly noticed in the Medicare services. For example—I am sure I do not need to state this—the further away you get from the capital cities the less likely you are to get a Medicare funded service because of availability and capacity to meet the gaps and so on that are required.

In the state funded service we are often in a position of having to make up for that. We provide the service that we provide in the city for people with serious mental illness. We often have to provide some of those other services to do that. I think what the member for Traeger is talking about is that there are gaps in all of that and we need to address those.

CHAIR: Member for Traeger, do you have an additional question?

Mr KATTER: I have one and it is on the same theme. I do not have the figures on me today but there was a severe shortage of psychologists. The last time we had access to psychiatrists visiting I am sure the availability times were severely depleted as well. Is there much work being done on how to address that? Clearly there is a problem with supporting those services like many other services. I do not like promoting telehealth as the solution because that can often mean a diminution in the quality of service. Is there any overarching strategy to address that because it seems to be ongoing and getting worse?

Prof. Allan: There is and I will ask my colleagues to address some of that as well. There is a national piece of work called the National Mental Health Workforce Strategy, which I think we have referred to. It certainly recognises that problem. The gap is not just in the state funded system but

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also in the privately funded system. There are incentive schemes to help psychologists go to rural areas. I am aware that in the North West there are a number of psychologist services that visit but there are not very many psychologists who live there.

In terms of psychiatrists, North West has a number of psychiatrist positions and generally they are filled. I will check with my colleague about the number of psychiatrists in North West as of today. We as a branch work quite hard to support those services and work with them.

This national workforce plan looks at some of those incentives that are required. The things that keep professionals out of the rural areas are the lack of peer support, the costs of living—the costs of accommodation and so on—and the difficulty in getting to professional support, going to meetings and keeping contact with their colleagues. There does need to be a differential for that. There are differentials in the medical salaries for that—not so much in the allied health salaries. I will ask my colleagues to talk about that.

That is something we will be addressing in our plan to look at that. We have quite detailed numbers about the gaps and needs. We will do that. I am currently consulting with all the CEs of those services around what those gaps are and showing them their data and checking that we have it right so that when we present data to you it will be right. I might invite my colleague to talk about the medical service situation in Mount Isa.

Dr Reilly: I have perhaps two points to make. Certainly the North West Hospital and Health Service does have three psychiatrist positions. That is my understanding at the moment. Plus they receive additional subspecialist psychiatrist input with regard to child and adolescent psychiatry. I could not tell you the exact amount of that. However, at the moment they have been having some difficulty, I think—again, I am not quite up to scratch. I think they might only have one psychiatrist on the ground at present. They have another one coming in February. As you would be aware, that is a recurring issue in smaller services with regard to being able to sustain any health workforce.

I think the only other comment I would make on that is that across Queensland Health there is an approach to rural generalist healthcare workers that applies across medicine as well as other disciplines. I think particularly with regard to the rural generalist program we have been working with the Chief Health Officer and with the Medical Advisory and Prevocational Accreditation Unit to try to look at the rural generalists who have advanced skills in mental health, which includes again AOD, to try to look at how do we get them connected better, how could we develop that workforce and support them working better with Queensland Health's specialist mental health and AOD teams. There is work in progress with that—we have funded the Cape, Torres and Central West. They currently have some positions there but not at the moment in North West.

Ms McBride: The geographic maldistribution of the allied health workforce is well known at both state and federal levels including for our mental health allied health workforces such as registered psychologists. We do know that about 60 per cent of psychologists work privately in Queensland and only 30 per cent work in our rural and remote services. The more regionally we go there is lack of access to those qualified allied health practitioners in both the public and private settings.

Through our allied health rural generalist strategy we have been trying to look at how we can support those positions within mental health services. Member for Traeger, we have been trying to get an allied health rural generalist training position within the Mount Isa Hospital over the last 12 months. That is definitely one of the strategies that we are employing for allied health.

Ms Miller: It is a very similar picture in nursing and midwifery as well with that maldistribution across the state, particularly in regional, rural and remote settings. We are currently embarking on a mental health nursing workforce plan, but there are a number of strategies that we already have in place that we are starting to progress. The rural generalist program is one of those. Mount Isa in fact has four positions that have been allocated to that hospital and health service associated with that pathway to try to increase the number of mental health practitioners that we have in our regional areas. There are 20 total positions that have been allocated to our five rural and remote HHSs to look at increasing that. That is one program.

We are also establishing a rural workforce hub that we are hoping will assist with some of those workforce shortages in that mental health area. Again, it is nationally recognised that there is a shortage of mental health workforce, and we are working at that level and also at the state level with the mental health branch to look at strategies for addressing that.

Mr MOLHOEK: Could you unpack that a little? You said you are working on strategies to get more people into these places. What sorts of strategies are you looking at? What thinking has there been around getting more professionals into rural and remote Queensland?

Ms Miller: That is a really good question. We are doing some workforce planning in that space currently with the mental health branch. Supply is definitely a challenge for us, particularly with the retirement of our mental health workforce. The average age is between 50 and 60—mid-fifties probably. We fully expect over the next five years a substantial retirement in that cohort.

Early career is where we are targeting with our graduates. We had 4,200 graduates this year. Interestingly, 20 to 30 per cent of those graduates actually put mental health as a preference. We are trying to increase that by building the profile of mental health nursing by talking to students and the universities about the opportunities. We are providing videos of positive experiences to try to increase the uptake in those areas. Again, it comes down to funding and the ability for those rural hospital and health services to take on those early career nurses from a skill mix perspective. We have to do it very much in partnership with them in a way that those early career nurses are supported from a capability lift perspective in those programs.

Mrs McMAHON: I wanted to start with the bigger picture, and that is the positioning of mental health within Queensland Health. I understand we have mental health, alcohol and other drugs all in the one branch, but it has been only a fairly recent thing—in the last 10 years or so—that we have had mental health and alcohol and other drugs together. Could you discuss the reasoning behind that and then further the intersection between mental health and alcohol and other drugs in terms of do people who are suffering from mental health issues generally have alcohol and other drug issues? Is there a causality? Where is the benefit and where are some of the negatives in having mental health grouped alongside alcohol and other drugs?

Prof. Allan: I will start and my colleague Dr Reilly will probably add a bit more to that. It has been there for about 10 years. Queensland is the only service that has them integrated at an administrative level. They were divided in New South Wales. The Victorian royal commission has recommended the reintegration of those services because of the degree of overlap. People with serious mental illness are more likely to have a drug and alcohol problem than not. Over 50 per cent are more likely to have that problem. When we admit people or people come into our care, clinicians would look for that problem—they would look to dismiss it rather than try to find it. It is very common. That is No. 1.

Of course not everybody with a drug and alcohol problem has a mental health problem. There are some separate issues around that. It is the same as there are many mental health conditions. There is a very broad spectrum of mental health conditions, so not everyone has the same mental health conditions. It is just part of that broad spectrum.

In terms of treatment, I think it is really important—and Dr Reilly might comment further on this—that we tackle those things together. The most common drug that is used in our community is alcohol. The next most common one is tobacco. They have enormous impacts on the health of people with mental illness. We need to address those things in particular.

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Whatever the treatment paradigm, you need to treat all those things at once. You can't separate them by this door, that door, treat this one first, then come back and get the next one treated. It should be a no-wrong door, everything should be integrated. Really that integration is built on the idea that for the vast majority of people, we are going to need to have those services combined and we should be doing that. Obviously we develop specialised services, like the opiate dependence service, services in prison and so on, for people with drug and alcohol problems that are a bit separate, but we need to have that together.

In terms of administratively, one of the things that I tried to highlight was the low spending on drug and alcohol. That has been a very sad traditional feature and one of the things that we have tried very hard in our plans, particularly our last plan, was to increase that spending. We think that it is a really underdone area, and it costs the community quite a lot of money. If you look at the commissioner's submission about the cost of untreated problems there. We think it is a good thing to have them together. Do you want me to talk a little bit more about the branch as well?

Mrs McMAHON: From a governance and also an operational point of view, the advantages of having those two areas grouped together, not only from a governance, but in terms of service delivery point of view.

Prof. Allan: From the government's point of view, it is the same story with that level of service delivery. When the drug and alcohol services were just floating around, they were going nowhere funding-wise and projection-wise. They had a lack of policy base, lack of adherence across the state. So bringing them together in the branch under a policy basis to actually be able to use a planning framework, the planning framework shows that we are very underdone. We have a policy basis for

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what we want to do and try to get some consistency across that. There are some differences in the way they are delivered. It is probably more likely to use NGO deliveries than mental health. So the higher split of NGO versus our services, but we need to have both of those parts of delivery. The integration really helps from governance standards quality. We have integrated the information systems to make sure that does not get lost for patients because once a patient gets siloed, they do not get the best treatment. We need to integrate that. John, would you like to add?

Dr Reilly: To disclose my bias, I am an addiction psychiatrist, so I could talk about this all day so shut me up when the time comes. The point I would make is that, certainly from AOD services, a number of people have concerns about being 'taken over' so to speak, by mental health services and feel that their particular client group could miss out in some way. The experience that we have had so far is that within Queensland Health, at least the HHS service system, where what we have been doing now, the policy, as you say, is only 10 or so years old, but certainly over the last five or six years, I think it is starting to move further. We are seeing now that within our hospital and health services, at the clinical level, there is greater connection between our AOD and the mental health services.

From the point of view of workforce, which we were just discussing, one of the big challenges, as Professor Allan said, historically mental health services have not seen AOD as being their purview. However, they do act in practice very often as a crisis service for AOD anyway for people presenting to emergency departments and certainly there are very high rates of comorbidity, as was discussed, for people with severe mental illness. Schizophrenia is one of the disorders with the highest rates of tobacco dependence, cannabis dependence and other substance use. I think it is important that mental health services have a good understanding, capability and capacity to treat alcohol and other drugs. Epidemiologically they are linked, so all the data that we present about mental illness and when you look at national mental health surveys, they include substance use disorders there as mental illness anyway. From a diagnostic point of view, certainly psychiatrists and other mental health professionals need historically and do diagnose substance use disorders, but often do not see it as a requirement to treat. What we have tried to do is to change that.

One of the things that people talk about with regard to AOD services is the difficulty, for instance, in getting addiction specialists. We have talked about addiction medicine specialists and addiction psychiatrists as being medical addiction specialists. It is interesting that there is that perception that we cannot train people because prior to being in this role four years ago I was in Townsville as a medical director and Townsville is a city of 200,000, at least. Over the last eight or nine years since that integration occurred in Townsville alone, we have trained four addiction psychiatrists; we had two more already there. It is possible to build capability across mental health and AOD to share, but not to remove the subspecialist nature of alcohol and other drug services sitting within a wider integrated service. We have tried to do that with then coming back up towards policy as well as back down.

Mrs McMAHON: Before I go onto my next question, Professor Allan, you were talking about the low funding of alcohol and other drugs. If I can split that from the mental health funding from the alcohol and other drugs funding, where does that lack of funding come from? I know there is a complex funding between state and federal government, but when we are talking about that historically low funding for alcohol and other drugs, where is the responsibility for that coming from?

Prof. Allan: History repeats itself. That is the major thing. So when you start with a low base and you have difficulty recruiting, then you do not get a whole lot of new services. I think that I am not the person who makes the funding decision, so I cannot really say who particularly is to blame, but certainly there are responsibilities for funding of drug and alcohol areas that are both with the state government and with the Commonwealth. So the Commonwealth does have some considerable funding that it does. It provides a number of the funding for the rehab services. The whole private system of rebates and Medicare that allows that work as well. So we need to work those two systems in conjunction. I can only say that in my time which has been the last seven years back in Queensland Health, we have been working very actively to increase that funding. We will try to do that. I am not sure I can say other than the funding models—the main answer to your question is—the funding models that are historic tend to produce the same thing next year and there needs to be a radical look and change at that. We have done some of that recently, but there obviously needs to be more.

CHAIR: For the benefit of the witnesses, if the questions are outside your scope of experience or authority, you are able to take those questions on notice and have them answered in a written format at a later date. We do intend to spend another hearing day speaking about funding matters and calling Queensland Health and the Mental Health Commissioner again, focusing very much on funding, so if you feel you need to take questions on notice, please know that.

Mrs McMAHON: We were looking at the intersectionality between mental health and alcohol and drugs. The other aspect I want to look at is where mental health and disability interact, noting that the disability network is an almost completely other beast, if you will. In terms of mental health experience in Queensland, and the disability sector, where does a mental health issue become a disability and where does a disability issue lead to a mental health issue? How does Queensland Health deal when it seems to cross over between the two?

Prof. Allan: You have asked a rather complex question and I will do my best. In terms of the mental health work, we are not a disability service; we are a health service. Many people with disability have health issues and we look to adjust our services around that and work with the disability service particularly NDIS and other service providers.

The change of landscape has been quite challenging, I think, for us because—and the major issue for us is intellectual disability rather than physical disability. There are adjustments that we make and do that, but probably the thing to note, particularly in the mental health area, is intellectual disability. So in some areas, for example, the UK, intellectual disability is regarded as a mental health issue and it would be the purvey of my branch and the mental health services. That has never been the case in Queensland. The only time that we become the primary providers of care for people with intellectual disability is through the Mental Health Act when a person is found to be have committed a crime and found have to a defence by reason of insanity, unsoundness of mind or through unfitness to plead and become a forensic disability order patient. That is about 120 people or so in Queensland. They are managed through the HHSs as their primary source of care.

Otherwise, intellectual disability was managed by the department of Disabilities, that has now been dissolved and so people are reliant on their NDIS packages, their other support mechanisms. It is actually quite a problem for mental health services because in the past, when a person with an intellectual disability, say, had a breakdown in their placement, things went wrong, they became depressed, they attempted suicide or whatever. We would work with the department of disabilities to ensure that there was a safe solution for that person, whatever the treatment that was required, whatever the housing solution, whatever the support solutions were. It is much more difficult with the NDIS because the NDIS says, 'I only do disability support. I do not do health care. You do the health care.' There is often a dispute about what bits of support are required.

To give you an example, say a person who has an intellectual disability is on the forensic disability order and their problem is about much abnormal sexual behaviour, so when they are out in public, they do things that would be considered inappropriate. That could be managed with supervision, distraction and redirection. We would say that looking after that person was actually essential for their life to help them to not fail in their life, but the NDIS might regard that as a clinical supervision rather than a lifestyle supervision and not provide that. So we get a bit stuck. We used to be able to do that with disabilities in the past. There is quite a big problem. I do not know if that answers your question, but it is a big problem.

Dr ROWAN: There has been a few questions this morning in relation to workforce. I want to go back to workforce specifically. I direct this question to Associate Professor John Allan as the Executive Director of Mental Health, Alcohol and Other Drugs Branch. With specific reference to the training specialist physicians and addiction medicines, so those who have done fellowship of the Australasian chapter of addiction medicine or addiction psychiatrists who have done the relevant advanced training addiction psychiatry through the Royal Australian and New Zealand College of Psychiatrists, has Queensland Health considered funding a dedicated statewide addiction medicine registrar training program in alcohol, tobacco and other drug services in collaboration with departments of medicine or mental health services? I ask that because other jurisdictions like New South Wales have provided specific funding for such training programs with quarantine places to try to build the capacity in those alcohol, tobacco and other drugs services and augment other service provision. The question really is: has quarantine funding for that been considered by Queensland Health and, if so, how many places would it fund?

Prof. Allan: Yes, it is has been considered and has been trialled. Dr Reilly actually ran the trial, so I might go to him to talk about that. There were some difficulties in recruitment. Perhaps you want to talk about that?

Dr Reilly: I will just note that I mentioned the rural generalist funding, so certainly another strategy from medical workforce strategy was looking at recruitment for addiction medicine specialists, as you would be aware. That excluded psychiatrists from respect to addiction, purely focused on medicine, and we worked with various addiction medicine specialists in some HHSs across the state to look at recruitment. Unfortunately at that time for a period of about 18 months, they were not able to recruit anyone into funded training positions.

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At that point, what I did was advocate with nah pal to look at if that is not possible, would they consider also supporting addiction psychiatry positions instead. They considered that in principle and there was, I think, an addiction psychiatrist training position created in Cairns, as I recall, at that time—but do not hold me to that—because at that time Cairns did not have any medical addiction psychiatrists. That is a challenge for us.

Clearly we want to see both addiction medicine specialists and addiction psychiatrists where possible. I think, though, looking at the generalist issue and I think there are perhaps advantages sometimes in more regional areas to having addiction psychiatrists, but we are certainly keen to get whatever addiction subspecialists we can into our alcohol and other drug services. When I say that, I am just talking more practically about who can we recruit who has that medical addiction subspecialty capability? Clearly we see that as important for building a broader multidisciplinary capability in alcohol and other drugs.

The only other point that I would make around that is you might be familiar with the UK perspective from a workforce which is looking more at subspecialists, generalist specialists and generalists with regard to alcohol and other drug competencies medically, and I think that to me is actually a good model to consider, that we need to be thinking about our psychiatrists in particular as being generalist specialists who should still be very competent when it comes to management of alcohol and other drugs. They are obviously not subspecialists in alcohol and other drugs, and then we need to think about how we support them. Unfortunately the experience therefore has been—and it is different to New South Wales because it has had a larger, longer focus specifically on that, that is addiction medicine—whereas we are being a little broader in our thinking in about both addiction medicine and addiction psychiatry.

004 **Dr ROWAN:** Are there any specific recommendations that you could give, so breaking that down into three sort of cohorts from a medical workforce perspective—specialist, generalist specialist and generalist in the area of addiction medicine? Are there specific recommendations in relation to recruitment and retention in those workforce areas to ensure the sustainability of the delivery of addiction medicine and of alcohol, tobacco and other drug services across Queensland?

Dr Reilly: Yes, I guess that has been the approach in what we have been trying to do. As we have looked at integration, it has been quite good to see that our executive directors of our HHS, mental health and alcohol and other drug services may have started thinking of themselves as running mental health services with AOD as tacked on. I think they now see them very much as integrated and that they have responsibility. From a regional and local perspective, whether in Gold Coast or Cairns, it is important that they have that. What that means then—and what we are certainly looking at—is how do we create more training positions both within psychiatry and also for JRMOs rotating through their mental health and AOD services, which is one of the ways for recruiting specialists historically, to give people a positive experience. I think that that then applies to other disciplines as well. Within medical, that is what we have been trying to do—trying to create those greater linkages. That has probably tended at the moment therefore practically to be more focused on the often large numbers of psychiatry training positions in some of our larger services; but, as you note, not much in the way of specific addiction, whether addiction, psychiatry or generalist psychiatry or addiction medical specialty areas.

We really are just trying to create that capability within our broader training. That has been the focus to date and what we would like to continue to support. The experience has been, as I said with Townsville, it is not just there. We certainly have seen a much greater capability amongst our psychiatrists more generally. Recently we have done a policy position which highlights that because our old one about dual diagnosis we have modified, so that is a co-occurring substance use disorders and other mental health disorders position in which we are really trying to emphasise what Professor Allan said about that 'no wrong door' approach and about the imperative for all of our mental health services outside hours when the AOD services may not be as available to be able to manage appropriately alcohol and other drugs. Certainly what we are hoping to see obviously is that over time that that spreads.

Ms CAMM: My question is in relation to psychology graduates and some of the challenges and impediments in recruitment. A number of graduates have either contacted me—but it is also written as well with a statement from the APS—in that there are now greater challenges when it comes to supervision requirements both on already practising psychologists and also those willing to supervise as well in that the supervision and the way in which that is undertaken has changed dramatically over the past few years obviously in an effort to improve services. We heard from Queensland Health about the challenges. Do you see that as a challenge in recruitment and workforce development when we have graduate psychologists who cannot obtain their full qualifications because of the load it then puts on existing providers or your existing workforce?

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Ms McBride: Certainly supervision for psychologists has been a challenge both in the public and the private sectors. The supervision requirements are set by the Psychology Board of Australia. The challenges really relate in part to some of the issues around the maldistribution of our workforce, particularly in those regional areas, for psychologists to be able to have access to qualified supervisors. The amount of workload that the profession has seen in the past two years means that that extra time that is required to be able to provide supervision has also been challenging for practitioners to find within their busy workloads as well. There are some sort of systemic structural issues, if you like, around access for accredited supervisors, but there is also probably a greater need for us to increase the number of our psychology workforce.

Mr MOLHOEK: Dr Reilly, or perhaps anyone on the panel could answer this question. You have talked a lot about the maldistribution of the workforce and the pressures that people working in rural and remote Queensland are under. How often do you actually get out and visit with some of these people in the regions, visit some of those health services and see at the coalface how that is functioning? Is it just anecdotal evidence that you are basing these comments on?

Prof. Allan: Dr Reilly and I are both rural psychiatrists. I spent 20 years in Townsville. I have a lot of connection to that in Mount Isa and other places. In the last couple of years I have to admit that I have not been out very much because of COVID. It has actually been trip after trip cancelled. I was going to go to Cairns yesterday for example, but it is just not feasible to hold a public meeting in Cairns or meet with so many people. I know Dr Reilly has a visiting program and will do that. We have very regular contacts. We run an executive meeting every month with all of those people. We hear their issues and we do that. For example, in COVID, we are running twice-weekly meeting just looking at the bed pressures, the difficulties that people are running with. We have a lot of contact about those issues and we know about them all the time. Our knowledge is very good and we have very detailed information about the gaps, the numbers of people and so on. There is very close contact.

Dr Reilly: I was only in Townsville for 15 years, so not quite Professor Allan's experience. I go out as chief psychiatrist and do visits to all of our HHS mental health, alcohol and other drug services and try and do a visit to all the services with in-patient units each year. Obviously that has been impacted also by COVID, but we have fitted around that. That is really for a review of how things are going, particularly from a Mental Health Act perspective, but because of some of our interests we do look at where they are up to with regard to quality, safety and more broadly. That is more kind of a touching base but, as Professor Allan said, we have a whole variety of meetings pretty much on a daily basis really with different HHSs about different issues. I think that that is across the mental health, alcohol and other drugs branch. I was supposed to be in Kingaroy originally planned today and yesterday.

With those visits, though, I have not been going out to South-West, Central West, North-West and Cape and Torres as frequently. I try and go each year but sometimes it has been every second year for those and certainly the fact that I go once a year does not mean that I do not sometimes go to other services more often than that. There are a lot of services obviously out there and even in going to those HHSs it is always impressionistic. I think we are reliant on the local management by the HHS and the management of those mental health and alcohol and other drug services to keep us attuned to what the local issues are. Certainly, we seek those out actively and they provide them assertively at times as well.

Prof. Allan: Dr Reilly and I actually share the chief psychiatrist on-call phone. One of us is available 24 hours a day available to those services. We discuss cases, difficulties, events and incidents all the time. I think that is fairly intimate knowledge.

Mr O'ROURKE: Thank you for being here today. My question is around the integration and service delivery from Queensland Health across other government departments, for example housing, police, child safety et cetera. How does that work?

Prof. Allan: Thank you, that is a very big question. At a policy level we have a link with all of those agencies, so we would work on housing, communities, youth justice. We have very strong links with police, ambulance, the courts, prisons and education. There are some ventures where we are joint partners, for example, in some of our youth work we actually share the facilities with education and provide education within our treatment facilities and so on. That has been a really good innovation. We provide support in prisons, watch houses, youth detention et cetera with clinical services and work closely with those services to do those things.

In terms of housing we have had various schemes. We have homeless outreach teams that work with housing to deal with those things. A lot of our work is across agency. That is actually very important because that is where a lot of the problems come from and they need that early intervention. Again, there is always a very great need. If you think about the number of kids in care, the number of kids going into youth detention for example, you can anticipate a lot of issues. We try to provide

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clinical services for those people, but there is a huge burden in the psychosocial world about disadvantage. You know that disadvantage is intimately linked to poor mental health outcomes. We work hard and we need to work harder. If you want more detail, I can certainly go into more detail of those.

Mr O'ROURKE: What about the relationship with federal government departments, PHNs?

Prof. Allan: We have quite a relationship with the federal department of health. We are currently working with the federal department of health around a national mental health agreement, and that is currently progressing. That is at a larger policy level. From a health point of view, we do not have as many relationships with other federal government departments, apart from health. Things like employment are a really important thing in the life of a person with a mental illness, we would be more likely to have a relationship with the state government department than the federal department about their policies, although this work that we are doing on the national agreement certainly has highlighted the need for those other federal departments and their state counterparts to be closely linked. I know that my colleague the commissioner will talk a lot more about some of those issues relating to the whole-of-government approach, but at a clinical level we certainly work with all of those departments on those problems. I have regular meetings at DDG, the junior director level and so on around that.

CHAIR: You previously mentioned issues in relation to linkages with the NDIS. How does the integration go in terms of trying to respond to mental health issues with NDIS and also the PHNs?

Prof. Allan: Queensland Health has a direct link with NDIS. There is an NDIS steering committee of Queensland Health. I am a member of that. I am not the chair of that. We take those issues through to the NDIS at that level. We also work at a local level with the local coordinators around that. We would bring issues to that committee and that would go through those processes. One of the things I meant to mention when we were talking about intellectual disability for example was the number of people with intellectual disability who have challenges in their placements who are actually occupying acute mental health beds. We work with the NDIS and the HHSs work with the NDIS to find appropriate placements to help get that package together for that person to get out. That has improved a lot in recent years. There has actually been some good work on that. I think everybody was confused at the start, but there remain a number of people where there are no providers. They have such challenging behaviours that the providers withdraw and they default back to us. It can be a long time until a new provider can be found to do that.

Of course, there is that group of people with psychosocial disability who are not covered by the NDIS but who certainly have significant problems that we need to deal with. That could be part of their mental illness or other disabilities and so on. The NDIS provides only about one-fifth of the psychosocial disability support to the number of people who are the most severe. There is a very large group of people where there is a gap in that psychosocial support. We need to note that as well.

We have a very good relationship with the PHNs. There are seven PHNs. They correspond to the Queensland Health HHS service needs. There is a joint planning framework. There has been a directive from the federal government to the PHNs about doing joint planning. We have done two rounds of joint planning with needs assessment and planning with the HHSs. This new national agreement will be about putting that more into action, so not just joint planning but joint commissioning and monitoring of services. A number of our HHSs have already got joint services and work with PHNs and have been telling me things like, 'Give us the money, we will work out how to spend it between us and the PHN and put in that service'. We are actually well placed for that kind of development around that, but we should also note that the PHNs have a very small budget. They only get a very limited amount of money to play with. They have a big task as well to do and we work with them.

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Ms KING: I am particularly interested in the workforce challenges that were outlined in your submission, and they are grave challenges particularly given the geographically dispersed nature of Queensland as a state. Could you speak to what role other state or federal government departments could play in helping resolve those workforce issues?

Prof. Allan: I think for the federal health department there is a lot that could be done. We mentioned some of the training places. I will talk about the medical training and then we can go onto some of the others. About 90 per cent of the training places for psychiatry registrars are provided by the state government. About 10 per cent are through the STP, the specialist training pathway. There is a rural training pathway that the federal government provide. They provide some but not all of the money for that. They provide about $130,000 per place. That covers salaries but it does not cover all of the on-costs, the supervision costs and so on. The deal is that the services get that or it might go into private practice. About 95 per cent of the training places are in public places.

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There certainly is an opportunity—and I think the member for Moggill mentioned this—for more training in the private sector through Medicare funded initiatives. There could be Medicare item numbers to help support that. There needs to be some more support for private psychiatrists to be able to do the supervision work. I know that they would do that if they were able to be remunerated appropriately. In terms of what they would do they would probably give a lot more than the money they were given. There are great opportunities to revamp that.

I declare that I was previously the president of Royal Australian and New Zealand College of Psychiatrists. I finished that in the middle of last year. We developed with the federal government a rural advancement program so that there would be more training places in rural areas and we could work to bring those places together. There is a lot more that the federal government could do in conjunction with the state government. We need to take those proposals forward as part of the negotiations we are having. They are not part of this round of negotiations, but certainly there is a willingness to do that and we would need to do that.

In terms of other agencies, there are certainly places that we already rely upon. There are places in military psychiatry. There are places in the prisons, youth justice and so on that we work with that are supplying additional opportunities for us to train more people. What we probably need as a basic framework, though, is an investment that allows supervisors to have time to supervise, as my colleague has pointed out, and we need a time for trainees to train in a safe environment so that they are not completely stressed out by the phone ringing constantly and thinking this is a terrible career and they do not want to do it. That applies across all the professions. There certainly are things that could be done in that way. I will hand over to my colleagues.

Ms McBride: I will pick up on Professor Allan's point about the Commonwealth. For example, the workforce incentive from the Commonwealth government that has recently been applied to general practitioners and nurse practitioners has not been applied to allied health professions such as psychologists, occupational therapists or social workers, for example. Similarly, in terms of some of the funding arrangements under the MBS for allied health interventions for mental health patients we are reliant on general practitioners for the referral to get access to the Better Access program number of sessions, but we are also then reliant on that general practitioner to understand the scope of practice of the different allied health professions that are able to deliver those services. We could see much greater use of our occupational therapy and social work workforces through MBS items if we removed the tiering system and we were able to promote better access to those workforces.

Ms Miller: Following on from Liza-Jane McBride, with nursing it is similar. There are opportunities with some MBS reform to increase access to private nurse practitioners in some of the rural and remote areas. There are similar issues that have been discussed.

Ms KING: I think you may have anticipated my next question. I was going to ask you as the Chief Nursing and Midwifery Officer and the Chief Allied Health Officer about scope of practice issues. Are there any specific examples you could speak to where scope of practice could be adjusted in any profession such that we could see positive impacts on the workforce? I was contacted by the Australian Counselling Association about a desire to talk about scope of practice for counsellors as an area that may have a positive impact on the availability of the mental health workforce more broadly. If you have any other examples or if you would like to speak to those issues please do.

Ms McBride: One of the challenges around scope of practice within our public mental health services is that we have defaulted to a case management model. We are having difficulty attracting those workforces that I talked about into mental health careers because they are not seen as attractive careers because the practitioners are not able to work to their full scope of practice. Because of the model that we have, there is also no career progression or pathway for clinical expertise. They tend to end up being team leader or team manager roles.

There is greater scope for us to access not just counsellors but access bachelor level qualified counsellors. We could look at what sorts of patients they would be able to assist in seeing under a clinical governance arrangement with a qualified mental health practitioner. There are number of other allied health workforces that could make a significant contribution, particularly around some of the cognitive behavioural therapy interventions. I am thinking about speech pathologists, psychologists, exercise physiologists and physiotherapists who can assist with some of those behavioural therapies. There is an untapped workforce for mental health services from the allied health professions and we need to look at how we can best leverage the skills and expertise that they can bring.

Ms Miller: Similarly in nursing, working to scope of practice and trying to get to top of licence is a priority for us, particularly in rural and remote settings. Recent legislative changes are going to support that. COVID has slowed us a bit in progressing some of those nurse-led models from an advanced practice perspective. There will be work happening in that space, particularly with mental health. That will be part of the workforce planning that we are undertaking.

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Ms KING: I was going to ask you to be explicit. What would you need from the state and/or the federal governments to see these reforms happen?

Prof. Allan: Can I answer that in one way. Liza-Jane has been a little modest. One of the things that happened under our last plan was to try to look at allied health scope of practice. We established in West Moreton, Metro South and a number of other places allied health clinics. We are able to go and practice as psychologists in the way you want to practice as a psychologist and have your patients and do that as a part of your public health job rather than having to moonlight on a Thursday night to do it somewhere else. We need to have a space and staffing to be able to do that.

There are a number of things where we would be able to work that into the things we need to do. For example, take the crisis that is going on in our emergency departments. Many of those people have a condition called borderline personality disorder. I do not want to talk too much about that. It is about a dysregulation of your emotions—feeling distressed and so on. They often end up in EDs. What those people need is not to end up in EDs but to end up in therapy. They need to have a DBT—dialectical behaviour therapy—and other versions of that. That could be supplied by those people. We have people trained to do that.

What we do not have is the space in the system to allow them to stop what they are doing in the crisis response to deliver that training. We need to have things that allow us to have the leadership, the training and the organisation that puts those kinds of things top of scope of practice. If you were able to do that psychotherapy work one or two sessions a week you would feel a lot better about all the other things you are doing in that response. That is what we should be able to do. We have proven that we can do that in some of those clinics. That has been very helpful in their referral. We are looking at some models around those kinds of treatments for personality disorders. There are similar things in eating disorders and various other conditions that we should be doing. Those are the things that need to happen.

CHAIR: Many years ago I was an official with the Queensland Public Sector Union and there was a lot of industrial work done around adjusting the career path in terms of the pay structure for allied health professionals, specifically to try to address that issue of allowing clinicians to continue to advance their careers while delivering clinical services. I know similar work has happened in nursing. I am from a nursing background. I know teaching and other professions have gone down the same path. Has that not had the sort of outcome that was hoped for?

Ms McBride: I think it has, but not universally across all our different types of services. For everybody's benefit, the scale goes from HP3 to HP8. The majority of our workforce obviously sit in the HP3 or HP4 area. It provides the opportunity to establish senior clinical as well as senior management positions at the HP5, 6 and 7 levels. What we see is some more senior level clinical positions in more of our physical health services. We have a well-qualified and senior HP5 and 6 clinical workforce in physiotherapy and orthopaedics for example. Because of our services and our service model within mental health what we historically see is that once we get to the HP5/6 level they are managerial roles. They have taken the managerial path not a clinical path. I think Professor Allan makes a good point that there is a real opportunity to create the space for those senior roles to be able to continue to work clinically.

CHAIR: Ms Miller, drawing on my clinical experience—it is six or seven years out of date—of both Metro North and Metro South there were a range of advanced clinical positions for nurses where the nurses were often acting in advisory roles around stomal care, wound care and a whole range of other things. There did not seem to be much in the way of support or advanced positions for physical nurses from a mental health perspective. Has that changed and are their opportunities around that, particularly in regional and remote settings?

Ms Miller: From a classification perspective we have the NG8, which is a nurse practitioner level. We have now had the classification of 7 and 8 recognised as a nurse navigator position. We have some mental health nurses who have taken roles in those areas. There is definitely an opportunity to encourage more people to move into that space. The program for a nurse practitioner, obviously if we could get further funding to support and increase the numbers taking up that opportunity, it would definitely be of value, particularly for our rural and remote areas. The other issue with that is that some of those nurse practitioners will go private and we still have the MBS issue that has raised that obviously needs to be addressed too.

CHAIR: Dr Reilly, you have something to contribute?

Dr Reilly: I have a comment to the specific questions. I know it was looking at nursing, but I think that that also highlights the issue of consultation and liaison services both traditionally for psychiatry as well as for alcohol and other drugs. We have looked to try to integrate those, but when

you are talking about a nurse working in a general hospital setting and support that is the service system that we would see as being available to provide that support, and they are multidisciplinary teams, but historically they have not been consistently and reliably funded and they have not always been as multidisciplinary as we would like.

Dr ROWAN: It sounds from a nursing, allied health and medical perspective that ongoing work on scope of practice reforms, models of care, how multidisciplinary clinical services are delivered that there is a still some work around how that articulates with industrial reforms and awards and the engagement of people in the private and public sectors. Would that be a reflection of some of the commentary?

006 **Prof. Allan:** I think you are right. Obviously the workforce is a big pillar of what we do. One of the issues is that we might create a position, but not have a person to fulfil such a role, so we have to grow them and we have to support them. We have inherited models from the nineties when we started to reflect around the multidisciplinary team is formed and the roles for people as generic, and I think we need to recognise that people have special skills and we need to use those skills in an appropriate manner. You would not like to be relegated below your skill level. That is certainly an issue. The big problem is that the volume that we have to deal with means that it is often not easy to just go off and have that bit of time away, or to say, 'I do not do this, I only do that,' because you have to do a lot of things to help keep people safe and make sure that your patients are not in a position where there is a safety issue for them. I think that is quite a stress on the system. The whole business about how we train, reform and recruit is really huge; I agree with you about that. I do not know if there is a particular thing you want to hear about that, but we have plans about just how we need to grow. That will take a while to grow that workforce as well, but without that, we are going to be in trouble.

Dr ROWAN: To a different topic, Associate Professor Allan, in relation to the role and function of Health and Wellbeing Queensland, which is an agency created under the current government, what additional scope does the Mental Health Alcohol and Other Drugs Branch see this agency performing with respect to health promotion activities as they relate to mental health and the alcohol and other drugs sector?

Prof. Allan: I do not run that agency so it is hard to talk about their particular policy, but I think that, in general, in health promotion there needs to be a greater emphasis on the mental health and wellbeing aspect. They are certainly promoting not just the healthy lifestyle, but they are also promoting things about youth and young people and babies as well. The growing ill mental health cannot be separated from the physical health aspects of promotion. You have to have a healthy environment, a healthy lifestyle, food to eat, to do all that. I would like to see all of the work that is done on promotion have a greater emphasis on emotional wellbeing and that is across the board—rurally, for our Indigenous population as well.

Mr MOLHOEK: I wonder if we could change the focus and perhaps ask Sandra Garner a few questions. I note in the briefing that the Queensland Ambulance Service is a legislated provider of pre-hospital emergency care and then it goes on to talk a little bit about some of the services through triple 0. I am very interested to hear some of your experiences, some reflections on how the service functions, and some of the challenges that you face. I am not trying to steer into the space of ambulance ramping or anything; I genuinely want to hear what are the challenges that the Ambulance Service faces, and are there workforce issues for you as well around people with the ability to deal with mental health clients and how do paramedics generally deal with that?

Ms Garner: Thank you so much for the opportunity. It is a really important and privileged position to come and sit here and be able to talk about the role that the QAS plays in the mental health space as well. I think that the QAS plays a really important role in a person's crisis. Often people have exhausted other avenues. Perhaps Lifeline, Beyond Blue, other helping professionals, people who are managed by the non-government sector will call triple 0 when their interventions have failed. We are there to provide that immediate service to people who are experiencing a mental health crisis.

From a QAS perspective, we see the mental health crisis as a very broad range of conditions of people who feel like they are in situations where they cannot cope with the stresses of everyday life, where they do not have the resources or the resilience to be able to deal with what is happening for them, and that is causing considerable distress and impairment in their life. They are calling triple 0 because they need relief from those symptoms and they need care at that particular time. The QAS is that responsive service.

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We have had, year on year, a growth of calls for mental health crisis. We have been counting these numbers since about 2015. We realised that the QAS needed to be able to be a really important player in that crisis response, especially for people who are experiencing suicide crisis.

In 2019, we decided that we needed to do something a bit differently. Paramedics told us that they did not feel they had the skills, knowledge and confidence to respond to people who are experiencing that mental health crisis. Of course, education was seen as a really important part of doing that, to train our paramedic staff to be responsive to people who are in a mental health crisis, but also we thought that our paramedics on the ground needed support and they needed to be able to have access to mental health clinicians to be able to provide them with information, advice and assistance to be able to do that. We were able to establish the mental health liaison clinicians who sit in the triple 0 operations centre and are able to provide that real-time support to paramedics on the ground. It has been a great partnership with Mental Health Alcohol and Other Drugs Branch as well, so we have access to the Queensland Health mental health database, and we are able to provide that in real-time service to the paramedics on the ground.

We are also able to, as the service has developed, talk to people in real-time who are experiencing a mental health crisis. We have developed procedures and policies based on needs and based on what we hear from consumers and carers about what they want. We are able to have people 24 hours a day in our operations centre who can speak to people who are experiencing that really acute crisis. We are able to make sure that they can get the most appropriate resources or information and advice at the same time as well. That resource might be an ambulance, and then it might be empowering that ambulance with the right type of information about what the treatment mode should be. It also might be providing a clinical intervention, some psychological education to the person in real time and diverting the ambulance away, so having a look at what other resources are available to them as well. That has been an incredible journey for the QAS to go on. It was a credit to the triple 0 operating and management team as well to accommodate that because it was a massive change of service to bring in.

We are very privileged to have fantastic staff who work there, but we have poached them from mental health services. In respect of the workforce shortages we have talked about as well, we are robbing Peter to give to Paul to be able to provide this service. I am acutely aware of that as well. I am in a very privileged position to have very senior practitioners work in that service.

The second thing that we were able to do over the last couple of years has been the QAS Mental Health Co-Responder program. This pairs a senior mental health clinician from a HHS with a paramedic to provide a first response to people who are experiencing a mental health crisis. This was something that was initially funded with no additional resources. It was something that was seen as something that we could do with a couple of HHSs, to trial it and give it a go. It became an amazing success. We are able to be a first response, a health response, a collaborative response with consumers and carers and patients on the ground, providing interventions that would normally happen in ED to people in their own homes, using their own resources. Across the state, we are keeping an average of 65 per cent of the people who we see out of the health system; they are getting interventions in their own homes. It is something that we have been incredibly proud of and, again, is a fantastic collaboration between the QAS and Queensland Health.

It needs to go from strength to strength. It needs a lot of ironing out. It needs a lot of operational type of finessing, but there is a lot of goodwill. The collaboration with Queensland Health has been fantastic. We are happy to see that go from strength to strength.

We have additional funding under Care4Queensland for four services a year for the next three years, so we will be able to roll out the model that we piloted in South-East Queensland throughout the state. This last financial year we rolled out to Cairns and Townsville, and we were able to take the model from South-East Queensland to a regional area. That was incredibly exciting to see that the model can work outside of the metropolitan area. As we go along and as the model strengthens, we will be able to have a look at what it looks like in regional and other remote areas as well.

Mr MOLHOEK: What do you call that model or that trial?

Ms Garner: That is the QAS Mental Health Co-responder program.

Mr MOLHOEK: You touched on the fact that 65 per cent of interventions are able to be done within the home. What does that look like?

Ms Garner: Keeping in mind that a lot of the people we see are experiencing suicide crisis, so either experiencing thoughts of wanting to end their own life or actively having interventions to do that, having a health model as well and having the paramedics go and do an appropriate level of health assessment—making sure that this person is okay, so making sure they have not taken an overdose, that there is not a biological basis for their behaviour, that there is no physiological ideology

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for what is going on, and doing that is the same kind of assessment that would happen in ED—the mental health clinician can then come in and do quite a comprehensive risk assessment, mental state examination, and get a history. The mental health practitioner is then able to put in place treatment plans which would be the same as what would be offered in an emergency department. Because they have links to the mental health service, they can, for instance, make a referral to the acute care team. They can make referrals to their other support services that are available locally for them as well. The mental health clinician will know what is available to people and be able to provide those interventions at home.

The benefit of being inside someone's home is that you are able to reality test your management plan that you are putting in place. For instance, somebody might say, 'No, no, I have my friend here who can look after me,' but if the friend is not willing or able or capable of looking after them, then the risk management changes. Being able to reality test your management plan is a real benefit of being inside people's homes.

The QAS is really used to providing services inside people's homes, and we have our co-responders who work for the HHS wear a QAS type of uniform. It is dual badged—it has a Queensland Health badge on it as well. It really does give us that access to people inside their own homes because people are used to having the ambulance provide that service in their homes. That has contributed to the success of the program as well.

CHAIR: It is probably too early for any research or anything, but, anecdotally, do you find that providing that de-escalation and management in the home environment is superior to putting people in an ambulance, racing them to hospital and then trying to have multiple people treat them in an emergency department?

Ms Garner: That is a really good question. Thanks to the Mental Health Alcohol and Other Drugs Branch, we were able to get some money to do exactly that research. We have somebody who is looking at that type of information and that data and some of the efficacy around the model that we have done. We will hopefully have that research out within the next 12 months or so. There are definitely benefits to being in people's own homes. We know from national and state research that mental health patients spend an inordinate amount of time in the emergency department. It is a high-stimulation environment. It is not necessarily the most therapeutic environment. As I have suggested, being able to have a look at the sociological circumstances that people find themselves in as well is incredibly illuminating for somebody's treatment planning. It has those benefits, but you are also able to use people's own resources, what is available to them in their own homes, at the time.

Something that we never anticipated as part of the pilot that came out quite extensively was that this model meant that our paramedics also felt that they had a lot more skills, knowledge and confidence in responding to people who were experiencing a mental health crisis when the co-responders were not working with them. They understood the types of questions that could be asked, the types of resources that were available and the types of interventions that could be put in place. It is really functional capacity building for our paramedic staff as well. That is something that we never anticipated and hopefully something that we can formalise in a bit of research as well.

007 **Ms KING:** I have one very brief follow-on question about the mental health co-responder model, if I may, before I move to my main line of questioning. You mentioned the dual badged uniform of the co-responders from the HHS teams. The way you spoke about it made me wonder whether getting mental health staff through the front door of people's houses in other circumstances might be challenging. You mentioned people are used to having ambulance officers in their homes. They are comfortable with that. Is that something that you see as a benefit of this model—that they are happy to have ambulance officers, paramedics, come into their homes where mental health practitioners may be subject to more stigma?

Ms Garner: That is a really good question. I might throw that to Dr Reilly and Professor Allan to address.

Ms KING: I am entirely speculating of course.

Prof. Allan: I think that is a really great question. There are probably two parts to the answer. One is that visiting people in their home is a really good idea, but there are always issues about safety. Over the years the notion that we would do community psychiatry in people's homes has been eroded to some extent by industrial issues of safety and so on.

When you are ringing in a crisis you want the help and you are inviting someone in to give you the help, so it is a bit different to going and seeing someone who has a lack of insight and does not really want the help but their family say, 'No. You need to do it.' That is a slightly different. However, I do think there is clearly a benefit in an established service. Similarly, people do not want the police

coming to do mental health things in their home either, but there are of course times when only the police can do what they can do—and we are very grateful that they are able to keep everybody safe in the way that they do. It is a very difficult question. It is an interesting question. It is difficult to answer exactly.

It does lead to a more general point which is that over the years the emergency department has become a bit of a focus of crisis in mental health, and it is not the best place. This is one example of the many things we need to do to do it differently. For example, we are developing safe spaces so that you can have peer support—so you actually have someone who knows your crisis rather than just a professional. We have the crisis support centre which we are trialling at the Gold Coast which is separate and has that sort of support for people. We are looking at different ways of doing it rather than just what was traditionally come in and be stuck on a booth with a curtain around you and tell your story to the whole world. We are working with emergency departments on changing that. All of these things contribute. Getting into people's homes is a good thing but people need to be comfortable.

Ms KING: Are we seeing that there is appropriate take-up of the referrals on for these clients? If they are referred on to an acute service or a Queensland Health community based service, do we know yet whether they are following those pathways in the way that we would hope?

Prof. Allan: I think, as Sandra mentioned, that is the research we are doing to try to find that out. Obviously if you do something and you want to refer someone to someone, you have to have someone to refer to. You have to know that that pathway works. I guess that is what the research is about making sure.

One of the big concerns for people in crisis is the follow up of what happens after the crisis. I think we have some data in the briefing we have given you about the number of people who follow up. We do not follow everybody up. We make a number of referrals back to general practitioners, support agencies and so on. I think that is the vital part. It is about having a linked up system. This is just another part of that linked up system. We are doing it. Do we have any data on that just yet?

Ms Garner: Not yet, no.

Ms KING: Obviously you cannot give us the outcomes of that research, but I think we would be interested to see what questions were being examined in the course of that research. Chair, is that something we could request on notice?

CHAIR: Sure.

Prof. Allan: I am sure that could be done.

Ms Garner: Yes.

Ms KING: Just to change focus, I did want to ask about this concept of the 'missing middle'. That is something that comes up in so much of the mental health reading that I have done in preparation for this inquiry. It is also something that I think many of us see in our electorates with our constituents. There are, to a certain degree, services available at the entry level where people's mental health issues are not yet serious. There are some anyway. Then Queensland Health provides acute services, but there is this idea that there is a gap in between those. Could you provide your thoughts on that and how Queensland Health can work with other agencies to bridge that gap?

Prof. Allan: That is an important question and one that is obviously facing everybody. The 'missing middle' is sort of defined as those people who are too sick just for their GP to handle but not sick enough to come into the publicly funded mental health service, except by crisis usually, to go into ongoing treatment. I think it is a bit of a bad definition because it talks about the patient's problems rather than the system's problems. Geography, your income, the availability of services and capacity—health literacy and so on—actually make a big difference to how big the gap is and where you fit. Obviously the gap is different for a person in Brisbane who has resources than for a person in Mount Isa who does not have any resources, for example. I think that is important to note.

It comes from a couple of things. One is that mental health and alcohol and drug services in Queensland have been traditionally funded for what is called serious mental illness. They are usually people with schizophrenia, bipolar disorder and serious depression but also things like eating disorders and some anxiety disorders. It is not limited to those conditions but they are at that serious end. It was always considered that primary care and other support agencies were for that middle bit. There is a gap in both systems.

The availability of just a general practitioner to see you with that lower entry condition often has problems about access and Medicare costs and so on. The ability to get a referral to a psychologist to do that counselling and the support treatment is actually limited by numbers. COVID has changed

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that. The number of sessions they can have has increased so there is less access because more people are having sessions. It is quite a complex thing. There is not enough in the private system to do that and there is not enough in the public system to do it.

What we are talking about with the Commonwealth is: where do we take up responsibility for some of that? Obviously we already take up some of that responsibility when those people hit crisis because we are the crisis service, but we need to go further back where we are able to intervene with those people who might develop a more serious condition. That is where some of the things we talked about like working at scope of practice and the psychology clinics and trying to nip those kinds of problems in the bud before they happen occur.

I am sure you are aware from COVID and from reading there is a huge deficit in the private sector because you cannot get an appointment to see a private psychiatrist. In fact, it is actually easier to get an appointment in the public system than it is to get one in the private system at the moment just because of the demand pressures.

I could talk for a long time about what the solutions are, but I think there are a couple of solutions. One is the joint work that we do with PHNs to try to identify particular cohorts that need to be given a good filter and a good gateway before they get into the crisis and before they get into our system. The other is about early identification—for example, GPs being able to use the plans and services that are available to them to get the right people into that early treatment, to get their depression treated and so on.

A lot of it is going to be around youth services as well because 75 per cent of mental health conditions emerge before you are 25. Once you have got past that, it may be a bit late. When we are talking about early intervention, you are perpetuating the problem, so it is going to be around how we do that and how we work with Headspace. For example, we are doing some further work on telehealth support for people with quite serious conditions. We are doing that with Orygen—a Victorian group. MOST we are calling it—which is around supporting those people who have emergent conditions to do online work and have online support as well as the therapy they are getting, because we want to stop them from rolling over but we need a lot more in that space. There is the problem of having enough money in Medicare and so on. I could go on about it, but I do not know where you would like to go with it.

CHAIR: I am going to call the member for Whitsunday for a question.

Ms CAMM: My question is in regard to the federal government funding. Your briefing outlined in particular the Head to Health centres and the need for greater investment in non-acute and middle level care to take the pressure off crisis demand—which makes total sense. My question is—and I am happy if you need to take it on notice—you stated in the briefing that Queensland is likely to receive a limited number of the Head to Health centres. I note the federal government's investment in that space is almost $500 million. Can you explain what percentage the state will be receiving given they have announced eight new centres and 24 satellite centres and maybe the reasoning if we are not getting a proportion of that?

Prof. Allan: Can I stick to facts rather than policy? I think that is really important.

Ms CAMM: I agree. I am not talking about politics.

Prof. Allan: We are getting about 20 per cent of the investment of those centres on offer. Our population is about 20 per cent, so that is about it. We are negotiating with the federal government—we have not done the negotiation yet—to get five of those and seven satellite centres. That is about our proportion of the money.

Ms CAMM: Sorry, I could not hear properly. Was that a number of satellite centres?

Prof. Allan: Yes, so five and seven over a five-year period. We are negotiating that.

Ms CAMM: Can I ask a subsequent question?

CHAIR: Hang on, we will just finish the answer to the first question first. There was a bit more to go.

Ms CAMM: Sorry.

Prof. Allan: We are negotiating with the federal government around five adult health centres with seven satellites. We are negotiating around some youth centres—two of those. I was going to say that, in terms of the proportion, we have a very regular consultation meeting with other states and territories and the federal government. We have information from all the other states to say that that proportion is about population weighted. The number is the number that is on offer.

Ms CAMM: As part of that negotiation, would it be a position that you would be looking at those satellite centres to include rural and regional Queensland as well as metropolitan Queensland?

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Prof. Allan: I cannot talk about the locations that we are negotiating about. Obviously our concern is for there to be a decent coverage for Queensland. It is the loaves and fishes thing, I guess. How do we turn that number into a proper coverage in rural and regional areas? That is a challenge. If I were speaking just from a developmental point of view, I would like to say, 'Let's start with this and see how we go and move on.' We are looking at a method of trying to get an appropriate distribution for that.

Dr ROWAN: My question is to the Chief Psychiatrist, Dr Reilly, and you may have to take this on notice. How many dedicated acute mental health service beds are available in Queensland in the public sector and how many alcohol and other drug detoxification beds are available in Queensland in the public sector? What is actually required not only now but into the future? I am trying to get an understanding across the 16 hospital and health services what is actually available but also, with forward planning as far as service provision is concerned, what is needed in the next decade.

Prof. Allan: I might start with that. There are 800 acute beds. There are about 1,500 beds in total. I think the acute beds are 57 per cent of the bed stock. You would have to do the calculation to get the others, but there are 803 beds. It varies a little bit from day to day according to beds closed with COVID and things, but there are around 800 beds. The tool that we use—the National Mental Health Service Planning Framework—shows that we have a shortage of beds. What we had planned to do was to give you all of that in the next submission, but I can tell you that the planning framework has recently been revised particularly in relation to the amount of stress that is on the presentations and bed numbers lifted up. We have a shortage across the board in beds.

008 One of the things the planning framework did was particularly separate out youth beds from the adult beds. Whereas before we used to go 0-18, 18-65, 65-plus, it is actually separating out a youth group—18 to 25s. We have quite a low number there that we need to address. Subsequently, there are issues in adult and older-age beds as well. I can take that on notice, but in the next submission we will be looking at that. That is what we intend to do.

Dr ROWAN: The Queensland state government is currently implementing a student wellbeing program in Queensland schools. It is $100 million over three years. They are putting GPs into state schools and also psychologists and complementing existing school nurses. Specifically, is the mental health branch being consulted on this program? Have you been asked to provide formal advice to the Department of Education on models of care or workforce issues?

Prof. Allan: We have been consulted. We are not providing models of care. That is being worked on because it is seen as a primary health intervention at that primary and secondary level rather than tertiary. We have a strong relationship with the Department of Health in relation to those kids who need that extra care and special attention. We have worked with them on a number of projects in relation to that, for example Jacaranda Place and so on.

Dr ROWAN: Just to clarify further to that, is there specific collaborative formal work between the Department of Health and the Department of Education in relation to the rollout of the program as far as models of care and workforce engagement or recruitment?

Ms Miller: The Hospital and Health Service children's health Queensland works very closely with the education department in relation to those programs. There are a couple of programs in that space. Yes, they are contributing to what those models look like.

Mrs McMAHON: My question is in relation to references within your submission about the people with lived experience and their involvement, particularly in relation to the commitment to actively involve the voice of lived experience. Can you outline to the committee what that actually looks like on the ground and what role these people have in decision-making not only at an operational level but also at a strategic level?

Prof. Allan: We have some data in there about lived experience. We actually have a lived experience workforce, and we are looking to build that up. We think there are particular roles for people with lived experience in helping people to be comfortable in the services. They have particular roles at end patient admission, in crisis services, and so on. We also see their role to make sure that clinicians are aware of lived experience issues at that clinical level and to advocate for people around that. At a policy level, services will have what is called a consumer advisory group where there will be consumers and carers who will work with the senior leaders around issues to do with welfare and so on. Data will be shared with them. For example, the results of those surveys about experiences of care would work in a quality way to look at improving that. There would be services where they would be members of executives and do that. For example, the lived experience coordinator is a member of the executive of Metro South. They are probably a more exemplary service, but they will do that.

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At a policy level at my level, the work that we do in planning and reviewing all services and every development is really done with consumers and carers in mind. All of those committees and all of those advisory groups, every time we do a project we have consumer and carer members of that group who will be equal participants. Usually when I work with them I work with those people in some of those more complex policy and development issues. We have pre-meeting briefs and we have people to support and explain to make sure that they get the most work around that. We are very proud of some of the co-design work that we have done with consumers and carers, particularly some of the youth, in responses to the Barrett Commission of Inquiry. Some of the youth services have been co-designed with young people, both people with mental illness and randomly young people and people from schools and so on giving us advice and working with the development teams around how that should work.

There has been a gap recently in the lived experience peak body. I mentioned that in there. Unfortunately, the peak body had to close some time ago. We worked to re-establish that body. We have been working with Health Consumers Queensland, Arafmi—the association of relatives and friends of the mentally ill—consumers and carers respectively to make sure that we have the appropriate consumer and carer representations in all of that work. 'Nothing about us without us' is the motto and that is what we want to live by.

Mrs McMAHON: Has any work been done in other jurisdictions that Queensland can learn from in terms of involving people with lived experience in design, development and implementation of mental health policies?

Prof. Allan: We think that we have led some of the way in some of that recently, but obviously we have modelled that on things that we have learnt from overseas. There have been things that we contributed—I will give you an example—in that the Victorian royal commission actually asked us how to do those things. We gave submissions to them to help them in that co-design aspect that they wanted to do. Yes, there are lots of things we can learn from everywhere. We can certainly learn a lot. A lot of the recommendations in the Victorian royal commission are very much along the lines we would want to have. I have learnt a lot from overseas contacts over the years about how co-design works that we have been able to implement. We always have a way to work. We consulted with some of the other organisations in the way they do that representation while rebuilding that consumer organisation. The New South Wales one has particularly strong values.

Mr O'ROURKE: In your submission you talk about the increasing number of people accessing services which is at a faster percentage than the population growth. You have touched on COVID. Are there other factors that are contributing to this?

Prof. Allan: That is a really important and interesting question. There are a couple of general factors. There is a move from the private to the public system in general. In Queensland Health there is a percentage shift across. We have more people presenting to us. Is there a change in the epidemiology? Is mental illness becoming more prevalent? That is a really interesting question that some people more expert than me could answer, but my understanding is that the rates of depression and so on are the same as they always were. We need awareness and an understanding that we have done a good job of promoting mental health awareness. The need to go and do something about that is great. It is fantastic that more people are presenting. It is just that it is very difficult to deal with them all of the time. That has got a part to do with it. Obviously COVID has had its part, but I tried to make the point that those increases were happening before COVID. COVID has really highlighted the sense of direction that young people have been feeling, and the lack of certainty in the future certainly seems to be coming. There are those eating disorder figures that I have talked about in other committees as well. I just think that people are wanting to do more about their mental health—and that is a great thing—and their families are more aware. That is a good thing, but we need the capacity to deal with that.

Mr O'ROURKE: In terms of the increases in populations, a lot of people are moving into Queensland. Has the federal government increased that funding because of those increases yet?

Prof. Allan: You are asking me questions about Medicare funding that I would have to take. That is done through the Medicare agreement. It is not kind of my knowledge, but I know on an activity base Queensland gets funded about population activity. I would have to provide a more detailed answer on that.

CHAIR: Do you want to take that on notice?

Prof. Allan: Yes.

Dr ROWAN: Further to what the member for Rockhampton touched on, what has COVID-19 meant for the mental health of Queenslanders? What is the data revealing that Queensland Health captures?

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Prof. Allan: We monitor the data that we get each week. The data is showing that ED presentations are much higher. In particular, I think there has been a 12 to 14 per cent—I think it is a 14 per cent increase. There is also a disproportionate increase in people with suicidal ideas—so that has been quite significant—and that has been quite a stress on us to provide that kind of service. We have responded by increasing funding for some of those direct services, but there has been quite a stress on the whole system because obviously we have more people in ED, more people getting admitted and so on. For example, last year for those 800 beds the bed occupancy was 103 per cent all of the time. It was over 100 per cent the entire year. The year before, it was actually 97, 98, 99, occasionally touching 100, but it has now been more than 100 per cent for that time. The sheer weight of that has been quite high.

Dr ROWAN: In relation to geographical distribution, is it consistent across Queensland or are there particular areas?

Prof. Allan: All of Queensland has experienced that, but probably the south-east corner, Gold Coast and the Sunshine Coast in particular have been affected. All of Queensland has experienced those kinds of figures.

CHAIR: It seems to me that Queensland Health is responsible for starting the process of caring for people when they have hit a fairly advanced point in their disease. Obviously it would be better to catch people early, to stop the disease and to prevent it from occurring in the first place. Given that Queensland Health's role is really in that space, if there were an unlimited bucket of money what would you see as the priorities for improving what we currently do? Are there opportunities to extend and to try to minimise those people hitting us at that point?

Prof. Allan: There are hundreds of priorities. But we need to make sure the crisis system does not just burst and we are not able to provide that care when people need it. We need to do that. We also need to go back earlier. We need to look from birth and pre-birth. We need to look at perinatal and infant mental health. We need to look at young people up to 11 and we need to look at adolescents. Young people is really absolutely a priority. My third priority, if I had to go for three, would be for indigenous people, particularly rural and remote indigenous people. The suicide rates, the rates of mental health conditions, really do need addressing. I take this advisedly, but that is an issue of a lot of other things than just mental health services. I do think we need really to be contributing greatly to that. There are many other areas. You mentioned me—and some of those are in the submission and we will talk more about those—but those would be my pick. That would be missing out on the enormous problems we have in drug and alcohol and the enormous problems we might have for people in the criminal justice system, child safety and so on. It is a deal to choose favourites.

CHAIR: Any other thoughts from other panellists? Okay—

Ms KING: Does the Chief Allied Health Officer wish to make a comment?

Ms McBride: I was just going to make the observation that we do not have good, affordable access either through the public or the primary health care system to allied health services, many of which are required by people who have those sort of chronic, lifelong, poor mental health issues that they are dealing with. There is the lack of access to dietetic input so that they have a healthier lifestyle. We need the ability to help them with things like severe insomnia, fatigue, weight loss—so really sort of behavioural-type things—but we just simply do not have the access. That is a contributing factor and a gap that none of the current strategies are really addressing.

Mr O'ROURKE: Professor Allan, you mentioned earlier that more people are accessing the public health system instead of the private sector. Why? Why is that shift happening?

Prof. Allan: People report availability and affordability. You and I probably have a really good GP. We see them and we work well with them but, when you get into a position without a GP, the service is not available to you and there is no access—as we have talked about in COVID—you find yourself in the emergency department. Emergency departments are actually pretty good despite all that is said. You get service, you get it done, and you get to see things happen. So people go that way. There has been a drop-off in private health insurance for all sorts of reasons which I will not go into, but that then makes people worry that if they got admitted 'What would happen to me?' They want to go private. They come to public just in case because they do not think they have the capacity for that. Those are factors that are probably bigger than what our services are, but those are things that I think contribute.

CHAIR: Are there any further questions?

Mr O'ROURKE: A million, but probably for another day.

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CHAIR: No doubt there are other questions. All members of the committee can certainly supply further requests for information from yourselves—not necessarily questions on notice but just a written request for information. We will certainly make all members of the committee aware that if you wanted to supply those to the secretariat we can follow those up with the witnesses here today. I thank you for coming in today. It has been a really good and broad discussion. There was one question taken on notice—actually there were three questions taken on notice and we need the responses provided to the secretariat by the close of business on Friday 28 January. We will now take a short break for lunch. The briefing will resume at 12.15 pm with the Queensland Mental Health Commission.

Proceedings suspended from 11.31 am to 12.16 pm.

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ALLAN, Associate Professor John, Executive Director, Mental Health Alcohol and Other Drugs Branch, Queensland Health

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CAYNES, Dr Simone, Director, Systems Planning and Response, Queensland Mental Health Commission

FRANZE, Ms Giovanna, Project Manager, Office of the Commissioner, Queensland Mental Health Commission

FRKOVIC, Mr Ivan, Commissioner, Queensland Mental Health Commission

CHAIR: I reconvene this public briefing of the Mental Health Select Committee. I would like to welcome the Queensland Mental Health Commissioner, Mr Ivan Frkovic. Welcome, Commissioner, and thank you to your staff for joining you as well. I would like to invite you to make a 10-minute opening statement, if you like, and your staff can assist you with that as well.

Mr Frkovic: I will do that. I might be slightly over because I have two hours with you. I am trying to capture everything as much as I can.

CHAIR: That is okay. We will give you some latitude.

Mr Frkovic: Thank you and thank you for the opportunity. Can I start by acknowledging the traditional owners of the various lands that we meet on and pay my respects to elders past, present and emerging. Can I also at the outset acknowledge people with lived experience, their families and carers, as this inquiry, I would suggest, is primarily about them. I would also like to acknowledge the tireless efforts, professionalism and dedication of so many people who work in mental health, alcohol and other drugs and related sectors, particularly during this pandemic period. Can I also commend the minister and the government for their leadership and commitment to establish this inquiry.

Over the coming months the committee will hear many stories, issues, challenges and needs, but people's lives and futures are at the heart of this inquiry. This opportunity is not only shaping the future of Queensland's mental health but supporting the outcomes that matter including for some of the most marginalised and vulnerable groups in our community. So let me briefly set the scene.

The scale and impact of mental ill health, alcohol and other drugs and suicidality are substantial whether we consider this from the perspective of the individual, the family, the community, the service system but also the economy. Mental ill health has a combined impact greater than any other health condition. Mental ill health is common, starts early in life, persists across the life span and has onset and some of the greatest impacts when we are meant to be at our most productive but also most engaged.

Mental ill health affects all Queenslanders either directly or indirectly and their families, carers, loved ones but also the broader community. As I am sure you may be aware, one in two Australians will experience a mental illness in their lifetime—one in two. But 75 per cent—and I think it is important to keep this in mind—of adult mental health disorders emerge before the age of 25. If unaddressed, addressed late or ineffectively, it can be associated with a wide range of adversity, disadvantage and lost opportunity substantially impacting on a person's life opportunities.

In terms of alcohol and other drugs, alcohol, for example, causes the most significant harm, is the leading cause of preventable injury and early death, and is a leading contributor to the burden of disease. Problems with alcohol and drugs do not discriminate. They cut across all groups in our society.

Suicide also remains a pressing issue in Queensland and, sadly, one death by suicide is one death too many. Suicide is the leading cause of death for Australians aged 15 to 44 years and is higher in our regional and rural communities and also in our First Nations communities. But also three out of four deaths are males. Queensland has consistently recorded suicide rates above the national average, with the second highest rate of suicide amongst all states and territories. Each death by suicide and suicide attempts have far-reaching and profound impacts on the individual, family and the broader community.

The combined cost of mental ill health, problematic alcohol and other drug use and suicidality is extremely high. For example, the cost of mental ill health nationally is conservatively estimated to be between $550 million and $650 million a day. These are not just numbers. They are highly personal, highly pervasive and can have long-lasting impacts. However, Queensland is not a blank canvass and a great amount of reform has been achieved. This we can build on.

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Over 40 years of reviews and reforms have delivered significant progress and change. However, each review has identified common and recurring gaps and issues. Since the 1983 Richmond inquiry in New South Wales, which is the one we go back to, the mental health landscape has undergone vast transformation at the national, jurisdictional and local levels. Each inquiry and review has identified urgent shifts and critical priorities to improve outcomes. However, after many years of reform, it is still largely the same conversation. Ours is not a problem of knowing what to do; it is an issue of action. Sustained, collective action is critical to achieve the systemic shifts and the lasting and effective reform that we all require.

We also must remember that the desired outcomes cannot be met by health alone and a whole-of-government and a whole-of-community approach is required. Queensland has a strong policy platform and strategic framework to work from. This is clearly articulated in the *Shifting minds: Queensland Mental Health Alcohol and Other Drugs Strategic Plan* and the various agency subplans. *Shifting minds* seeks to achieve the outcomes that matter through three focus areas: first at the individual level to ensure better lives for people with lived experience and their carers through person-centred and integrated services; second, at the population level through improved population mental health and also early intervention; and, finally, at the whole-of-system level through a balanced approach, collective action and strong governance. I will briefly speak to these three focus areas to signpost the compelling issues for your further consideration.

Better lives for Queenslanders is at the heart of the reforms that we need and require. Better lives is about supporting people to live contributing and satisfying lives with agency, dignity but also purpose. Despite significant progress, we consistently hear from people with lived experience and their families and carers that it is challenging to access the right support at the right time where it will benefit people most.

The fragmented and patchwork design of the mental health system means the onus is on the person and their supporters to navigate and advocate for the care they require. It is designed that the mental health service system primarily services the two ends of the spectrum—which I think the member for Pumicestone asked about in the previous session. It focuses at the mild and at the severe ends, with people in the middle missing out due to being too complex or not complicated enough for the services provided at either end. We must do better to understand and respond to the needs of what is normally termed the 'missing middle' as a priority.

Our system is also largely imbalanced to late intervention which is harmful for the individual and significantly costly to service those systems and governments. The increased demand for mental health services, as has been identified by Dr Allan, has overwhelmed the system across public, private and the non-government sector. This has obviously been exacerbated by the pandemic. Over time the service system has been required to raise its access threshold—which is what we discussed earlier this morning too—to ensure support to those most in need. Unfortunately, this means that people are turned away until they are in significant distress or absolute crisis. Alternatively, we regularly hear that services largely offer assessment and triage, with referral becoming the de facto intervention. This also means there is limited scope to address the specific needs of at-risk communities such as our Aboriginal and Torres Strait Islander people, LGBTI people but also people from culturally and linguistically diverse backgrounds.

Unintentionally—and I say unintentionally—we have established a hospital-centric service system where the emergency department has become the front door of all mental health care. As a result we have a system that focuses on system management, treatment and intervention and not one focused on population mental health and wellbeing.

Improving clinical and treatment outcomes depends on ensuring a person's holistic needs are equally attended to, for example and including housing, employment and social isolation. If you think about the beds question that was asked before, surveys have suggested that 30 per cent of admitted patients in psychiatric wards could be discharged if appropriate housing and community services were available—30 per cent of our beds could potentially be made available.

When people do receive services, we know from the data that clinicians spend on average between 20 and 29 per cent of their time directly facing clients—20 to 29 per cent. This is significantly less than the 67 optimal proportion of care identified by the National Mental Health Service Planning Framework, which Dr Allan referred to. This is compromising for both the clinicians but also the consumers, clients and families. In addition, it is estimated that only 28 to 48 per cent of demand for alcohol and other drug services is met. This means that a number of people who need and seek AOD treatment in any given year will not have their needs met, and unmet need is even higher, as we know, in rural, regional and remote locations of Queensland.

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Adequate support requires a community based system where psychosocial support is a fundamental element that complements clinical treatment in the community. We also know that treatment alone is not the answer unless we focus—and some of the questions earlier were about this—on how do we prevent illness but also how do we intervene early wherever possible. Investing in these areas is where the best buys and the greatest return on investment lies.

Every single one of us is susceptible to mental ill health. Our mental health is not static. It slides up and down a spectrum of what I would call vulnerability depending on what is going on in our lives. In fact, much of the potential for improving mental health and wellbeing across the population does not lie in the health system but within those settings where we live, where we grow, where we learn, where we work but also where we age. There is considerable knowledge and evidence to demonstrate that mental health promotion, prevention and early intervention can reduce the prevalence of mental ill health, change life trajectories, stem service demand but also reduce the pressure and cost over time on our public mental health system.

Queensland has pockets of excellence and has led innovation in a range of areas that are renounced nationally and internationally. In particular, we have strong foundations and linkages across human service portfolios that contribute to important ways to individual and collective mental health and wellbeing. These include across the early years. I think there was a question initially around Queensland education, workplace health and safety, housing, employment. We do have some good examples. However, an overarching systemic approach is lacking including prioritisation of these things and resourcing to the extent necessary to have large-scale ongoing impact.

Mental health promotion and prevention and early intervention continues to be a poorly defined area with regard to both accountability—and we are talking about state and Commonwealth accountability: who is responsible and I think there were some questions about that earlier—and priority. There is urgent need for increased, sustained and tailored whole-of-government commitment and strategies at least in these areas as a starting point: early years, having the best start in life, including preventing and reducing the impact of adverse childhood experience—we can get some major gains there; children and young people, particularly in schools, in child care, in various contexts; community wellbeing; but also workplace mental health and psychological safety. Each of these areas will yield major benefits across multiple sectors, systems and the economy.

010 Our best chance to improve outcomes is to stop the pipeline that feeds mental ill health and creates excessive service demand. The cost of no action or limited action is immense, as we know. Finally, unless we have collective action across governments and across sectors, people with lived experience will continue to fall through the patchwork of service silos and the mental health burden will continue to grow.

Improving the lives of people with lived experience and ensuring people stay well, remain well, or return back to wellness requires a whole-of-government approach that is supported by all levels of government across sectors. This requires collective action—we keep saying this—as opposed to siloed approaches. Our mental health system is imbalanced and largely geared to costly hospital services, including over-reliance on the public mental health system. This means that despite ongoing growing investment, there is a significant shortage of certain bed types and community clinical services in the public system, as my colleagues from Queensland Health have identified.

We need to rebalance from a hospital-centric approach to one where community services are at the centre, where both clinical treatment and psychosocial support is provided to people, including those that may not get an NDIS package. We need to rebalance from late intervention to providing support across the continuum of need including upstream prevention and early intervention, whether this is early in age, early in vulnerability or early in illness.

We have many examples of good reform, and this includes the Medical Benefits Scheme, however, implementation will continue to be challenged if barriers to accessing MBS are not addressed, including affordability, but also the limited workforce and the discussion we had this morning beyond the urban centres. Any public-private NGO reforms will be difficult to implement unless there is a strong focus on addressing workforce shortages—you have had a good discussion this morning about that—including inequitable distribution of that workforce across Queensland. We need to leverage the contributions and influences of non-health sectors and portfolios to support the best start to life, safe and inclusive communities, but also pathways to social and economic participation.

Finally, all of what we do needs to be informed by, grounded within, and led by various voices of people with lived experience and their families and carers. I would like to talk to you more about that, about some of the feedback that I have had, about the establishment of this committee and how people with lived experience and other key stakeholders can have input into this process.

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The reform ambition is more than improving parts of the mental health system and requires more than system adaptation. What the system does not need is more of the same. To get better outcomes, we need to do things differently.

CHAIR: I will start with a couple of questions. In the submission and in your presentation here you talk about the importance of the first 1,000 days in terms of improving overall lifetime health and wellbeing. What is currently happening in that space? Is it, again like many other things, spread across both state and federal government departments and the NGO sector?

Mr Frkovic: Yes, there is quite a bit occurring in this space, but, as I said, scale and distribution is still not where it needs to be. The Queensland government, for example, have a very deliberate policy statement of giving every Queensland child the best start. That is certainly focused policy direction across agencies and across community about what we can do. We have certainly seen investments in a whole range of areas such as, for example, the Right at Home program, the Child Connect type of services—there is a plethora of these being done, but again program-wise, not systemic-wise. We have some real opportunities. For example, when I talk about this, I say that interventions at this point need to start at the point of conception, in utero, and the first 2,000 days. If you give the child the best start during that period, you see the trajectory change and you have long-term savings in other systems such as child safety, youth justice and drop out of education.

My message around all of this is that the evidence is clear. We do not need more evidence. They have been following young people for 25 years in this space. What I have said and what I have tried to say is that we need action. We need really concerted action and investment in that space to be able to make a huge difference. We have some pockets of excellence, but that needs to be much more systemised, if I can use that word, to become part of not only our DNA of our society but also of our service delivery system.

CHAIR: You said in your opening statement that the overarching strategic approach is lacking. Can you expand on that? Where does that strategy sit and why is it lacking? How do we address that?

Mr Frkovic: I am not sure that I recall saying that there was a lack of strategy. What I did say was that the Queensland government has a strategy which is called Shifting Minds which really cuts across that individual, better lives, invest early to save, and make the system work better. I think we have the strategic direction, as I was trying to say. I apologise if I put that across wrongly. I think we have the strategic direction. It is the action. Obviously, as with any of these things, the pie is only so big; you are trying to invest across a whole range of areas. However we are thinking about where are our best buys at this particular point, both currently and also of this generation growing up into the future, and I think that is where the argument sits.

I think we have the strategic directions. Even the Commonwealth government has now produced a child mental health strategy—a child, so not a youth—a child mental health strategy. Through some of the funding in the last budget—and John alluded to the national partnership agreement—there will be some Head to Health kid centres rolled out. However, as was said earlier, and I think the comments that someone made here around how many Head to Health centres, even in the adult and in the child and youth, it is a good start, but it is really minimal in terms of what we need to be able to deal with the extent of need that is out there.

CHAIR: When it comes to preventative health or population health strategies, from my perspective it seems that things like Head Space and Beyond Blue and those sorts of entities, that a lot of these NGOs are somewhat driven by their own strategic plans but funded federally. To what extent does your agency or other Queensland government agencies have input into those sort of federal pushes in terms of preventative and population health?

Mr Frkovic: It could always be better, but I think we do have quite a bit of influence, more so than, as John mentioned previously, theirs is more the link with just federal health. Ours is across all federal government agencies. We do work strongly with the national Mental Health Commission, as our leverage point. Therefore, working between the state commission and particularly the federal national Mental Health Commission, we look at influencing those national priorities, agencies, funding decisions et cetera as best as we can, particularly to benefit obviously the priority groups in Queensland and what we need to do, but also to make sure that Queensland gets its fair share.

Dr ROWAN: Following on from the member for Greenslopes, in the Queensland Mental Health Commission submission, there are a number of references to needing a population mental health approach to public policy. Given what we know about the psychosocial determinants of health and

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the risk of adverse childhood experiences and those risks for mental health you have already alluded to, what I really want to specifically drill down onto is: what are the specific components needed for this public policy framework here in Queensland? Are there specific recommendations that you can give the committee that would assist in that being implemented from a public policy perspective?

Mr Frkovic: When we think about, for example, adverse childhood experiences, a lot of those things already sit within various agencies. If you are a child who is born into a family, for example, that has unstable housing, domestic violence, drug and alcohol problems, one parent who has been incarcerated or has a mental illness—there are 10 or 11 of these—if you are born into a family where there are four to six of these, your trajectory for poor mental health is pretty set. From a policy perspective, all of those things that we need to do in those other areas will also help in terms of the adverse childhood experience. What are we doing around domestic violence? What are we doing around drug and alcohol? What are we doing around stable housing and employment? All of those things are critical aspects to help the environment into which a child is born.

From where we sit from a mental health perspective, I was fortunate to look at this overseas—we have started to move into this space—for example, in Sweden, when you have a child, you get 15 home visits whether you need them or not. It is not just by a maternity nurse; there is a team of two people who come. One is a social worker who looks at the context that the child is born into and the other person is looking more at the health of the child et cetera. Proactively we are looking at supporting that family in those early 2,000 days. Again, we do not have a systemic approach in Australia anywhere around some of that stuff, that proactive supporting of families when a child is born into a family. We have some vulnerable families that need a lot of support, and we do not have a systemic approach. We do provide some maternity services, as we know, but is that extensive enough? Do we provide the broader services that those vulnerable families need? I would suggest not to the extent that we need.

Ms CAMM: My question is in relation to how Queensland's mental health system could better meet the needs of rural and regional populations in your view, keeping in mind all of the things that you have already outlined as challenges?

Mr Frkovic: I do not want to keep harping on the concept of telehealth and telepsychiatry. We know that—and one of my colleagues here with me has a particularly strong background in this—telehealth and telepsychiatry are useful as complementary elements to a mental health response. They cannot be the only response. This is certainly coming through fairly strongly. Where I think we could do better when it comes to some of the rural and regional matters—and I know there is always attention on whether we need beds or whether we need community services—I think some of the better options, particularly if we provide more broader community services where people can come in early—I think providing community services to the rural and regional communities is probably the best way to go, rather than waiting to get four, five, 10 or 20 beds into your hospital.

John mentioned that the national planning framework is now weighted towards rural and regional. We have some other ways we can try to do that. I think it is about those community services. This is not just about public community services. I need to be really clear here. When I talk about the system, I am talking about the federally funded aspect—the MBS—the private, the NGO and the public system. We have to grow that community mental health sector overall. If we grow it and we target it particularly to the regional communities, then you are more likely to get the services that you need rather than just waiting until we build more beds in your hospital.

I do not think that beds are always the answer. Beds certainly are an important component of our mental health system, but if we just rely on the beds, then I think we have a challenge in terms of—as I said in my intro, we have, over time, and I think unintentionally, built a hospital-centric system when it comes to mental health, and ED seems to be the front door for all the mental health at the moment, particularly for people in crisis. We have to shift that. If we shift that, then I think there are more opportunities to better meet the needs of people, particularly in rural and regional parts of Queensland.

Ms CAMM: Following on from that, Commissioner, do you believe that there is a recognition by all three levels of government around the nature of the decentralised region that Queensland is and that there is an agility? My question really is around where do you see the need for improvement for that whole-of-government approach across the three jurisdictions and the NGO sector to recognise that a collective model or a recognition of that decentralised jurisdiction and the geography that we have is so different? Do you see that there is flexibility that already exists, or is that something that needs to be considered further by all levels of government in the sector?

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011 **Mr Frkovic:** Overall, if you look at the national Productivity Commission report and others they are all talking about working better across federal, state and local governments to get better outcomes for people. I do not think we had as much flexibility prior to COVID. Flexibility is much more evident since COVID. We have seen a shift in the way we fund and the way we get money out the door and support people. I think that is starting to happen.

When I think about that question from a systemic perspective, I talked about some policy misalignment. For example, regional Victoria is very different to regional Queensland. You can drive for two hours in Victoria but you cannot in Queensland. You have a two-hour flight and you still have a car ride after that. Some of those concepts do not always sit well, particularly at a federal government level. I am not trying to blame anybody here.

I think part of the policy alignment is around this. We need to think at various levels about trying to achieve some of the outcomes—particularly that you are talking about for regional Queensland—but also about flexibility. We also need to think about what we all talk about—integration. Integration is something that gets thrown around easily, but is it really taking hold. I think what is required is that we need to have a common purpose between all levels of government. What are we trying to achieve here? That is a critical aspect. John has referred to this around some of the co-planning between PHNs and HHSs. I would say that we should not just include PHNs and HHSs but also include the private sector and non-government sector in that local co-planning.

The other bit which we have started in Queensland to a small extent—we could do a lot more of this—is co-commissioning. Let us put all the mental health dollars in a HHS on the table, whatever they are, and say, 'If we were purchasing services for this community, what would they look like?' We should co-commission those services for the needs of that local community. We know that there will always be a need for more dollars, but with the dollars that we have, as I have articulated to you, could we do better?

Thirdly, wherever possible—and this is not going to work always, particularly in a state such as Queensland—we need to look at the things around collocation of services meaning people do not have to shop around. As I said to you—and I think I put this in the submission—I refer to the missing middle. People will say, 'Head to Health is good, it is bad or it could be better,' but there is a gap there. If we can mould that to a point where it becomes the new front door for mental health rather than the public system or rather than our EDs then I think you would shift the system away from a hospital based system. Those centres are not going to help all parts of Queensland. As I think John mentioned, there will be centres and then some satellites so some of the regional work could be linked through the satellites.

If we shifted the system towards the middle ground where more people could get in early and stop the trajectory of people getting in late and ending up in EDs and in the public mental health system then we would have shifted the system in a different direction. That is what consumers, families and the broader community are calling for.

CHAIR: It sounds just like cancer.

Mr Frkovic: That is right. If I can pick up your point. Would we say in a cancer treatment approach, 'Wait until you are in crisis then come and see us. Wait until you are stage 4 then come and see us.'? Would we ever say that in a physical health environment? In mental health we have to use that sort of analogy. When I am experiencing things early that is when I should be able to get access to supports rather than waiting until I am so unwell that I am in crisis, the ambulance needs to be called out, they need to transport me or at times the police may need to be called in to transport me to the emergency department. That is exactly your point, Chair.

Mr O'ROURKE: I want to look at Indigenous communities and the more remote non-Indigenous communities. How would you categorise the level of primary care that is provided by GPs or private providers in those areas?

Mr Frkovic: I do not have the precise numbers, but I know the broad issue. The broad issue is that when it comes to some of the discrete communities in rural, remote and regional areas in particular wherever possible there is a strong strategy around supporting community controlled organisations to deliver those services. Mental health gets funded by both the federal and state government through those community controlled organisations.

The challenge is a workforce issue as well. Can you get a psychiatrist or a GP and a whole range of those players to work in those communities? Some of those issues are very similar. The advantage of the Indigenous model is what we talked about earlier. The Indigenous community control model is probably something the mainstream community is calling for as well. You can come in and get support without being triaged—either you are too complex or you are not complex enough.

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With the Indigenous model that brings together state funding, Commonwealth funding, MBS funding, block funding and individual funding through NDIS they can mould all of that. It is challenging, and I am not saying it is not challenging, but they provide that holistic response. I have heard a lot of consumers say—and I do go across Queensland quite a lot apart from the last couple of years with COVID—'Every service has an exclusion criteria. Which service has an inclusion criteria?'

I am sorry to say—that is probably a gross generalisation—but that is how consumers and families feel. I was speaking to somebody yesterday about a similar issue. These Head to Health centres have to be like the Indigenous health community controlled organisations. They have to be the point of entry rather than public mental health services at the end where you have to be acutely unwell and in crisis before you get in.

Mr O'ROURKE: The coordination of services is easier in some of those rural and Indigenous communities. Beyond those, do you see that there are big gaps in mental health service delivery in regional Queensland?

Mr Frkovic: John has the planning framework targets. In the public system—if I can talk about the public system—we do have a shortage of certain beds which are distributed across Queensland. I am not going to go into the details here. You will get from the planning framework which type of beds. We are also lacking in community clinical treatment services across Queensland. That is at that severe end—again, John's end.

In places like Kingaroy, Mount Isa et cetera mental health services operate very differently to the ones that operate in Brisbane north or Brisbane south. They take a much more, if I can use this phrase, population health approach. They are not just clinicians. They work in a community context with people. In those respects, I think it works well.

What we do not have is a lot of non-government organisations that operate in some of those smaller communities and provide a broad range of psychosocial support services. That is really becoming evident as a result of the NDIS. Lots of people are getting packages, but, unfortunately, spending only 50 to 60 per cent of their package. That is particularly challenging for people living in rural and regional areas. You get a package, but who are you going to purchase the service from? Who is going to provide that service? Even though people are getting a package they are not really able to utilise that package because, as they say, through the NDIS there are thin markets. There is not someone to deliver those services.

We have to think about how we support the non-government sector to provide more services particularly in rural and regional areas. Apart from NDIS we do have a problem when it comes to psychosocial support—non-clinical support—for people who do not have an NDIS package. I put into my submission that at best by 2030, 88,000 people nationally with psychosocial disability will get an NDIS package. We will get 20 per cent of those who require this. The number of people who are in the severe, complex, enduring mental health illness stream in the table which we gave you is much larger than that. How do we provide additional psychosocial support and who is responsible for providing that for those people who do not get an NDIS package?

The final bit is around MBS funding and private health insurance et cetera. When you go to regional areas we do not have the workforce but also there is the issue of the gap payment. People seeing a psychologist 10 to 20 times are asked to fork out a gap payment every time. We know that even when it was 10 sessions that people could have that on average they used 4.5. We do not know all the reasons for that but we certainly know that the gap payment does exclude people.

When you think about private providers—I am going to make a general statement—I would suggest that when you go out of the Greater Brisbane area, not even South-East Queensland, your chances of seeing a private psychologist or psychiatrist or getting into see a GP is pretty complex.

Mr O'ROURKE: I want to touch on a comment you made earlier in regard to COVID and the challenges that have resulted around service delivery. Do you believe there are opportunities with technology for better service outcomes in regional and remote communities?

Mr Frkovic: Technology certainly plays an important part. We saw that through COVID. Sorry to use this word again, but we pivoted very quickly in terms of delivering both clinical and non-government services to people in their own homes using technology et cetera. When you think about the mental health cohort, particularly people with severe, complex and enduring mental illness, what we also learnt through that process is that not everybody has a smartphone and not everybody has access to the internet. If you are in regional Queensland you may not have access to the internet or have some of these things. We found that even though we pivoted very quickly people did not have enough data on their phone to even link because they could not afford it or did not have a smartphone.

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That is why I said that technology is useful as a complimentary to the existing face-to-face system. If we totally rely on it, particularly in our space when it comes to mental health and drug and alcohol, it is a real challenge. Technology is one option, but I am not sure it is the total answer to what we need.

Ms KING: I was interested to hear your comments about the missing middle. In the mental health space that is what many of us hear from our constituents day-to-day—that is, they are not complex enough or they are too complex for the existing services. I would like your comments please on if that missing middle were to be filled what would that look like? What would those services look like? How would they best be funded? I will leave it to your discretion as to how deeply you want to go into that question given we are going to be talking about funding in later sessions. Could you give us some examples of the kinds of community health services that might provide that missing middle?

Mr Frkovic: I think there are answers to this. I going to stay within the lanes of the current configuration of funding. For hospital, clinical and severe the responsibility is clearly on the state government and the Queensland Health system. Having said that, I see all of the other parts being the responsibility of the federal government. That is my opinion. I see that as a responsibility of the federal government, unless things change. At the moment, they are the lanes we operate in.

The federal government funds primary health care, private psychiatry, psychologists. People at the mild or to some degree towards moderate is what they manage. Private hospitals also play in that space. If something becomes more complex or acute they will refer people to the public system. That is what the federal government does. Because the states only responsibility is the space I outlined, the other space seems to be the responsibility, at least from my perspective, of the federal government.

That is why I said in my submission that in terms of the Head to Health centres—without knowing all the details of how this is going to roll out; I can speak for some experience as I used to run things like this before I came into this job—there is an opportunity to think about community based centres, whatever we call them, as the gateway into mental health. The federal government has started well with five of them and seven satellites and two or three for kids. Can I suggest that we need probably one of those to cover anywhere between 50,000 and 70,000 people in Queensland—one per 50,000 to 70,000 people. You can see how far we need to go. It is picking up the Chair's point earlier, it is a little like when the federal government took responsibility and funded over 150 headspace centres across the country. This is early intervention. In the primary healthcare space that is their responsibility.

As Ivan Frkovic as, the Commissioner, looking at the planning and all of these things, I would suggest that we need probably 100 plus of those adult and child and youth ones to be able to manage that 'missing middle'. If you think about the productivity commission chart, just in Queensland we have 470,000 people in the mild group, we have 260,000 people in the moderate group, and then you have about 160,000 people in the complex/severe group. We are servicing probably half of that group, if not a bit more, by the public system; the other half probably is not in there, so you can see the gap between picking up some of those and the mild. There is a big group in the middle that really needs services. To me, the way the current arrangement between our Federation is organised seems to sit as the responsibility of the federal government. I would like to see them roll out more of these Head to Health centres. Whatever they look like, let's make them work for us but make them the front door of mental health—not the public system and not the emergency department. Am I speculating a bit here? That is Ivan Frkovic and that is his experience and knowledge in this space as best I know it.

Mr MOLHOEK: Thank you, Ivan. I have so many questions written down; I do not know where to start. I want to dive in with a bit of a philosophical question or perhaps a comparative question. With regard to the mental health crisis we are seeing, how does Australia compare to other advanced or developed economies like the UK or America? Is there any evidence or data around how mental health sits in Third World countries? What are the rates of mental health incidents and approaches? How do they compare? I know it is a big question. Some people talk about it as being a disease of western culture or disease of affluence. We seem to be creating a society that is geared towards greater isolation and less dependence on others, so therefore there is more disconnection.

Mr Frkovic: I think Professor Allan can also provide us with some of his experience. From my understanding of the situation, the prevalence of mental illness generally has not really skyrocketed over the last 25 years. It has pretty much flatlined, but again keeping in mind that some of that data does come from certain countries that collect it. That is the baseline for the last 25 years. The data fluctuates, but if you look at the last 25 years there is a lot of data. It fluctuates, but it is roughly stable. We have seen increases in ED presentations, mental health presentations et cetera, particularly as

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a result of the pandemic, and John outlined some of that data. We have seen that in children and youth, we have seen that in the adult system, we have seen that for services online, presentations to ED and eating disorders. There has been a disproportionate increase in terms of young people in particular. We are probably similar to most other western countries in this sort of space. From my understanding of what is happening in Canada and the UK we seem to be similar. As John said, we have not seen the increase in the rates of suicide that were predicted as a result of this.

As I said in my introduction, Queensland has always had pretty high rates of suicide, but in terms of broader presentations across the country we are all seeing similar types of presentations increasing as a result of the pandemic. Suicide has not been that issue at the moment, but as you have probably heard in some media outlets, the mental health pandemic is still to come. I think the impacts of COVID will still be around and will continue to increase for the next 12 months to two years, if not three years. That is when we need to start to prepare to also continue as services get more requests in terms of support and intervention. How do we make sure that we have the services and supports—not just public, but GPs and NGOs—to do that? In a roundabout way, the prevalence seems to have continued roughly the same for 25 years, but they have not looked at what bump that will provide as a result of the pandemic. That is just in general. We have seen a spike in individual countries, including Australia, when it comes to mental health presentations, particularly during the last two years during this pandemic.

Mr MOLHOEK: This is a slightly different tack, but I am interested in your comments on public housing and affordable housing models. There has been a shift to more efficient housing models and more one- and two-bedroom apartments away from houses. Do you think current models of public and affordable housing are conducive to supporting mental health outcomes and dealing with issues like social isolation?

Mr Frkovic: We could have a whole session on social housing. It is a critical aspect of good mental health. We built the Queensland government's *Shifting minds: Queensland Mental Health Alcohol and Other Drugs Strategic Plan* on four pillars: timely access to good clinical care; timely access to good psychological care; access to affordable housing; and access to employment and training. They are the four pillars of any good mental health system anywhere around the world. Can I say that no-one really has got those levels right. Everybody is struggling with all of that.

I am certainly not here to represent any government, but particularly in relation to COVID the department of housing achieved phenomenal outcomes around getting homeless people off the streets and placing them into accommodation. Not only off the streets into accommodation but also then transitioning them into long-term social housing. With all of the challenges around the type of housing, they were able to move the bulk of those people into long-term social housing.

That is not to say we cannot do more, specifically around people with mental illness. We know that it is really difficult. As John said, we have about 1,500 beds in Queensland, and on any one day 30 per cent could be freed. Imagine the saving if we could free up those beds for the people who need them. It costs approximately $1,500 a day to be in an inpatient unit. You cannot free up those beds unless you have appropriate accommodation and support in the community. I think there are some real options around thinking outside the square with regard to the models and how we offer them.

Queensland has been leading in this area. Recently, until the NDIS, we had what was called the Housing and Support Program. When a person was moved out, particularly from some of our large institutions, we gave them housing, clinical support and psychosocial support in the community. Most people by far were not readmitted. Most people have lived in the community, so the outcomes are really strong and powerful. When the NDIS came, the Queensland government—like all governments—transitioned those programs into the NDIS because that is where they were more appropriate. I still think there is a need for us to think about models such as the Housing and Support Program for a broad range of people, because I think one of the principles the national Productivity Commission report pushed very strongly was 'no discharge into homelessness'. Whether you are being discharged from prison, youth detention or from health, we should not be discharging people into homelessness, and discharging them into a boarding house is probably just the same as discharging them into homelessness.

I think we have to think about various models. I would like to see some dedicated models like we had, thinking about the stock of housing, different configurations and how best to meet the needs of people with mental illness who will have some challenges around social isolation and living in congregate living, whether you are in a unit block or an apartment. The work that the department of housing has done as a result of COVID, moving people off the street into student accommodation in

Toowong, shows that it can be done, and it has been done effectively. In fact, not only has it been done to move people off the street but also to place them into long-term social housing.

Mr MOLHOEK: One of the benefits of the Toowong trial is that it is a housing model is designed for socialising. A lot of the new public housing models do not incorporate areas or opportunities for socialisation. If you live in a one-bedroom flat with a flat-screen telly and your own private bathroom, you have the basics in terms of your human rights, but once that fire-proof door shuts you may as well be in a prison cell. I think that has a horrible impact on people's mental health.

Mr Frkovic: Yes. We have been doing some work with the state architect around a whole range of these things. The thinking of someone with an architect's background is interesting: of how do you build communities in terms of the subdivision of land; how do you design housing which is more conducive to social interaction rather than hindering it? This is an interesting point.

Some time ago, when I was much younger, I was involved in Project 300, which involved taking people out of psychiatric institutions and placing them back into the community. We evaluated this over 10 years. We took 300 people out. The last evaluation we did was with 173 people we still could find and track down. On every life measure and outcome measure their lives improved apart from one: social isolation. They had a flat in Coorparoo. They had their clinical case manager coming to see them every week. They had their psychosocial support worker, but that was their only connection. We have to work much harder at helping people, particularly in that transition out of hospital or out of community care units in the public system et cetera into community to help them regain social connection in the community. Otherwise, we can do lots of good things but, as I said, unless you have social connection, purpose, meaning and friendship, life becomes pretty complex and difficult.

Mr MOLHOEK: With the implementation of the NDIS one of the complaints I received in the last year has been from community programs that run drop-in centres or community support programs. The bottom line is that people are not going to lob up and pay $30 a day out of their package to be at a drop-in centre, but those drop-in centres are really important. How do we bring that service back?

Mr Frkovic: Consumers tell me this every day and I have had discussions with Health et cetera. To get any of this psychosocial support there is a huge gateway, and I have to work through this gateway before I get any support even to go to a drop-in centre. With the NDIS we packaged support, and this is what we determined you can purchase and buy and where you buy it. Then there is a smaller bucket of money that primarily is funded by Health for psychosocial support. But because the pressure is on them, the gateway into those much broader services is through Health. So unless you are in Health and going into one of those services, you do not get a service.

People say to me every day, 'I used to go and see my PHaMs worker, personal helper and mentor'—which the federal government cashed out once the NDIS came—'I used to be able to go to a drop-in centre,' but we do not have funding streams at the moment. We fund some of that broader community infrastructure where people can go and socialise and interact. Because everything now is a gateway we say, 'This is the menu of things you can buy in NDIS.' Queensland Health through its funding says—and rightfully so, because it is a small bucket of money and they want to control who gets into that—'This is the gateway into this, and this is what we provide for so many individual sessions and group sessions.' I suppose everything is sort of—what is the word I am looking for—determined in relation to what you get and what you are eligible for. There is not this broader funding where people can provide a whole range of innovative services and drop-in centres et cetera like, for example, clubhouses and a whole range of things. For all of the issues people have with clubhouses, the issue is—Joe, you would know—they provide a phenomenal service for people who are isolated and not particularly well socially connected.

Mrs McMAHON: I wanted to turn your attention to the crisis aspect of mental health and particularly the role of emergency departments. I know you stated earlier that emergency departments seem to be the window or the first point of call for many people into the mental health space. Your submission, though, is that there had been up to a 70 per cent increase in emergency department presentations due to mental health. However, what period of time are we talking? Do we have an idea what some of those factors are that are contributing to that increase?

Mr Frkovic: That is national data. I do not have all of the details of state data. I think John did allude to it. That is national data over the last four or five years, I think, from my recollection. I am sorry, I can—

Mrs McMAHON: The trend would be relatively similar for Queensland, the experience?

Mr Frkovic: The trend would be relatively similar. It is across the country. It has become the front door of mental health.

Mrs McMAHON: Some of those contributing factors for that might be?

Mr Frkovic: Again, the contributing factors, from where I sit and what I see, is that people are getting into treatment and support late rather than actually when things start to unravel. I think my colleague from the Ambulance Service spoke about people are in what we call in mental health a situational crisis. Things are happening at home: problems with finances, problems with domestic violence et cetera et cetera. That could trigger a whole range of mental health reactions for me. But if I do not get the support there, those things I deal with to a point where they become a crisis because I am not getting the support. So where do I go? Ambulance, police or ED. That is the trajectory. This is the problem with the system. It is late treatment. It is treatment at the more expensive side of the system rather than being able to go and see somebody like we talked about, these Head to Health centres, that I can go and see somebody when things start to unravel for me, where I am not in a crisis yet, but I am certainly heading that way, but I need some support to be able to deal with that. That is a critical aspect.

To give Queensland some benefit, we have established, for example, at the Gold Coast—and I think John referred to this—a crisis stabilisation unit, an alternative to emergency department for mental health, drug and alcohol and suicidality. If you get a chance, I would recommend you go and see it because it is not far from ED, but it is a different environment. It does not provide the stimulus et cetera or waiting in queues when you are in the ED and all those things which cause additional problems for people with mental illness.

We are in the early stages of that. It seems to be working well, from what I understand. I was down there, probably a couple of months ago now. I think at some point we should think about how we have more of those across the state once that works. John also mentioned we have these safe spaces for people that may be in a situational crisis where they do not need to be waiting in ED, but not far from ED. We have these safe spaces where they can go, talk to a clinician, a peer worker, a support worker, to help them deal with that situational crisis which has brought them there.

Mrs McMAHON: I was going to ask about issues of using EDs as a triaging centre for mental health, but I think you have probably answered that one. I spent a good 10 years as a first responder transporting people because either ambulance were not there or because of the level of violence that was exhibited that they would not go in an ambulance. Can you comment on some of the co-responder models that are being either implemented by QAS or QPS and the impact that they are having on ED presentations?

Mr Frkovic: I think my colleagues this morning mentioned that they are actually doing some data analysis, evaluation research, but there are some other co-responder models with police, for example. I am fully aware of the one in West Moreton that was recently evaluated. The decrease in presentations and de-escalation is somewhere around, off the top of my head, 70-75 per cent. It is really effective in terms of dealing with those situations. Rather than sending just a police officer or an ambulance officer to those situations, there is a mental health clinician as well who can deal with some of those situations.

As my colleague said, if we think about it, again from a systems perspective in this way, 60-65 per cent of people where there is an ambulance callout, their situation is dealt with in situ, in their own home. The other 35-40 per cent get brought into ED. Out of that group of that 35-40 per cent, based on some of the knowledge that I have and from some of the contacts that I have had, between 5-10 per cent do not need to go to ED if there was an alternative to take them somewhere. Either you deal with it in home or in the ED. If there is not an alternative provided, that 40 per cent comes into ED.

So a system that provides those alternatives will also take pressure off the Ambulance Service and address some of the things that we have in terms of them waiting when it comes to hospital, but also the people that need ED services—remember EDs were established for physical, medical emergencies. They were never really established for mental health. I was around a long time ago, probably like John, when we institutionalised from the park to the general hospitals, but we never really retrofitted mental health into the ED. This is a general statement. EDs were never really designed for mental health or drug and alcohol.

Mrs McMAHON: Just on that and harking back to what you were talking earlier about the missing middle and the need for preventative work, particularly when you identified that percentage of the population that are in that mild category, or even the at-risk—

Mr Frkovic: Moderate, yes.

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Mrs McMAHON: —we hear it regularly from our constituents about how hard it is for anyone to get an appointment either with counselling, psychologists or a psychiatrist. If you are a parent and you have concerns about a child or a pre-teen—because we know that is where a lot of these issues develop—and you are cognisant enough to recognise that and you go, 'Well, my child needs help and I want to be proactive,' it is then a six to 12-month wait to get them even into a first-off consultation. Isn't that where we are letting early prevention slip by and then we are starting to slip into acute mental crisis and long-term mental health concerns? Is there a quick fix? Is there a middle ground? Is there a long-term fix for these unrealistic waiting times to deal with mental health issues amongst our young people?

Mr Frkovic: I am not sure there is a quick fix, but there are certainly things that we could do more quickly. Some of the matters that were raised earlier around the workforce and how we manage some of this stuff I think could be done better. In fact, I did some work with Minister Di Farmer in her electorate. There was exactly this issue around young people and in particular schools that needed a whole range of mental health support. It also involves being able to inform people about how the system works.

As I said, a lot of people fall through the service gaps because there are so many elements. As a parent, I start to worry about little Johnny in terms of how he is acting, what is happening et cetera. Where do I go for some help? The first point of call might be, for example, around some of the online services, some of the phone services. You start to see some of this, but then you get to a point where you say, 'Well, I probably need some more face-to-face interaction.' Also you might then think about, 'Well, should I perhaps try to access, say, the headspace service?' I used to run headspace. That is a very basic first point of call for young people with a whole range of mental health, bullying or drug and alcohol issues.

Mrs McMAHON: Under-12s are not eligible for that service, is that right?

Mr Frkovic: It is not available for under-12s. That is the problem. We have a service gap generally. We have infant and perinatal infant health in Queensland Health but again it is for the more severe, and this is where we do not have that service for zero to 12. I do think that the new Head to Health centres which the federal government will fund—and I think there are only a small number of them—are targeting the zero to 12, so they will start to address some of that. That is only a drop in the ocean in terms of what we need. You have a gap primarily between zero and 12. Then you have relatively, I would say, good services. Headspace, as I think I put in my submission, with all of its challenges around funding, provides that first step into some level of support, but I know that even at the moment headspace wait times are three months, four months, depending on which headspace location. That is your first point. If you have a family GP, you may go and see a GP and he or she may say, 'We will see if we can get you a psychologist,' but, as you say, your wait might be six to 12 months because of the workforce shortages and the pressure.

I know the federal government in its best intentions said, 'Let's increase it from 10 to 20 sessions,' but in fact what that has done is halved the number of sessions that people can access. Before with 10, there was more of us being able to access it. Now with 20, only half of us can access it. Even though the policy intent was good, the way it played out is challenging. I think we need to think about those things. Then you scale up from there: the GP, headspace, then to some of the child and youth mental health services where you could potentially go. From the online or phone services to the clinical system, people need to understand that, and it is hard because people tend to want to get in when they see this crisis and it is left until a later point.

What I said to the parents at that particular meeting was that we need to also identify some of these things that are going wrong at an earlier stage. Now the schools are picking up. In fact, your point earlier was about the Queensland government has funded 50 schools with GPs in them which will help phenomenally, but also 464 allied health professionals across schools. Again, unfortunately it will not meet the littlies because it is for the high schools, but this is also going to fill a gap when people cannot get to a private psychologist. I think there are elements of the system building, but I think we are struggling to systemise it and really scale it to where we need it.

Dr ROWAN: Commissioner, coming back to what you touched on earlier around the siloed nature of some of our government departments and people who are accessing different packages or funding, are there any recommendations around machinery of government changes which would be in the interests of consumers or mental health services and, analogous to that, like in other jurisdictions, there are dedicated ministers for mental health to try to assist with having a broader range of portfolio responsibilities to go across health and justice, housing, child safety and education? Are you able to advise the committee as to how effective such roles have been in other jurisdictions

and whether the Queensland Mental Health Commission has a view on having a minister for mental health in Queensland?

Mr Frkovic: I have worked previously with a minister for mental health. The Hon. Curtis Pitt was the first minister and, I think, the last minister for mental health that I recall. There are challenges with mental health being siloed, but also there are challenges with mental health being imbedded within Health. It is a two-edged sword. For example, if you take out mental health dollars, as we have seen in other jurisdictions, then that becomes like a junior portfolio with usually a junior minister so their ability to influence is much harder. When you are part of a big agency such as Health with a senior minister, you are more likely to be able to influence. There are pros and cons with that, but having a minister who just dedicates most of their time, if not all of their time, on mental health does assist, particularly in the current climate; for example, where our minister obviously in the whole department is focused on COVID. It is a big issue to have to handle for one minister, so in these situations maybe the support of a minister for mental health would be useful. Generally there are pros and cons of that approach.

When it comes to funding, there are models where, for example, us and New South Wales have very similar commissions based on New Zealand. We are much more system commissions that look towards helping government establish strategy policy. We support implementation, but we also hold governments and the agencies accountable for progress, implementation et cetera. For example, the West Australian commission actually commissions services, so they hold all the mental health dollars, public and NGO. There are pros and cons with that, too.

There are some issues from, say, a commissioner of mental health and AOD, where I do have lots of opportunity and have my hand on the policy lever to drive some of this change, but I have to say I have no hand on the funding lever about where the dollars go. In fact, we work really hard with agencies. The government over the last four or five years has allocated new dollars, but none of that money comes to us; it goes to the line agencies who are delivering this.

014 Is there a hybrid bit between being a commissioning commission versus our current model? I think that needs to be thought, because if you want to drive change, if we continue to do more of the same in the same way, will we achieve the reform that we need? Does it take some level of opportunity where the funding maybe does sit somewhere else for a period of time before it gets embedded into agency-based budgets to ensure that the changes happen before it becomes part of their base budget? It is worthwhile considering.

Dr ROWAN: Just as a follow-up question to that—there could potentially be some scope for the Queensland Mental Health Commission to have a fund-holding responsibility beyond what currently exists, based on the jurisdictional models. Coming back to the notion of a minister for mental health, given that there is involvement with housing, justice, education and other things, is it a model where you could potentially have a minister for mental health who has some input into multiple agencies, in other words a super portfolio, and not have it as a junior ministerial one because of that influence that needs to be exerted from a government perspective across multiple portfolios or multiple departments? Are there any sort of existing models around that which you are aware of jurisdictionally in Australia or internationally?

Mr Frkovic: Not that I am aware of, but certainly some of the more mega departments as you remember we certainly had here in Queensland but also in Victoria where mental health was part of a mega department and a mega minister. It had its pros and cons. Your point around having a mental health minister who is not just responsible for the public mental health system but also housing, employment and a whole range of things around mental health could potentially be a beneficial way to go. That has not been what happened historically. Historically, for example, the minister at the time was really responsible for both public and mental health even though at the time the Minister for Health still held most of the public dollars, but the NGO dollars sat with communities with him at the time. I think there are some learnings from that, but having a mental health minister who has a whole-of-government approach to mental health could potentially be beneficial.

In terms of the commission holding dollars—I have to put my biases on the table here—when we were developing this commission I was involved. I was asked to come back after five years to be the actual commissioner. I was not supportive of a commissioning commission. Having been in the role for five years and seeing how difficult it is to drive change, I am still not convinced that having a commissioning role is the way to go, but some hybrid model between a commissioning commission and what we have now would be worthwhile thinking about what that would look like.

Mr MOLHOEK: I have a very quick comment. There was an attempt to establish a special social services cabinet back in 2013 which required all the heads of those different ministries. In fact

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I just found the original brief, but I think it is classified so I cannot share it! That is what you are talking about to some extent.

Ms CAMM: My question is around the overrepresentation in what is outlined for suicide rates, in particular the prevalence of males, and the 65 per cent higher rate of suicides from regional communities. Can you outline—and if there is an evidence base to this—the contributing factors? You have outlined the lack of access to services more broadly in regional and remote communities, but does that contribute to that? Given you have outlined that the trend has not really changed too much since 2011 and that clearly not too much impact is being made, can you focus on that cohort?

Mr Frkovic: As you know, all suicides are complex and multifaceted. There is no one thing that I think is just the thing we need to focus on. Certainly, when it comes to male suicides you see that the trend between 35 and 45 is the highest sort of peak. There are compounding factors. I will talk more about this, but we are doing some more in-depth analysis of the data now with the coroner. We know that, for a person in that age range of 35 to, say, 45 who currently loses their job, who currently has relationship problems and who currently has drug and alcohol problems, it certainly puts them into a much higher risk group when it comes to things like suicide.

Having said that, we are doing some work now with the coroner, as I said, looking at deep diving into male suicide in terms of the coroner's information, looking at some of those more detailed contributing factors which are really interesting. One of the things that comes out so far—and this is just general information so it is not conclusive at this stage—is that marginalisations are coming through very strongly. Most of these men to some degree are marginalised. We can talk about definitions of marginalisation, but they are marginalised. Most of them have had contact with the criminal justice system or spent time in corrections. Most of them also have drug and alcohol problems, but what was also interesting, at least with the early cohort—and we are still going through about 170 of these—is that they have also seen a GP in the last two to four weeks and were prescribed antidepressants. That is what the data is starting to show about some of these things.

It is not conclusive and there is a whole range of other factors, I am sure, but that just gives some insight about where potentially some of the interventions lie where we could make a difference going forward rather than, as we have historically, looking at, 'Well, we know it is males, we know it is around family problems, drinking, losing a job et cetera.' I think we are getting much more sophisticated now in understanding where potentially we could make a difference if we were to really look at reducing that rate, and we are. We are still the second highest in the country. We lose more people to suicide than we do to car accidents. We just really need to think, 'How do we have a concerted effort?'

In Queensland, the Queensland government is certainly supportive of a whole-of-government approach. Our philosophy and the way we are driving this is around every touchpoint is an opportunity to intervene. Whether I turn up to housing, employment, Queensland Health, child safety or wherever, every touchpoint is an opportunity to intervene. That is the power of the message in that we have to get out there, particularly when it comes to men, as you know, who are not very good at help seeking and who are not very good at—I am making a gross generalisation here—talking about how they are feeling.

Mr O'ROURKE: Commissioner, as you would realise, I worked in the housing and homelessness sector for many years. You mentioned the PHaMs program no longer being funded. In working in that sector, we did a lot of on-the-ground referrals for people in social isolation, people stuck in units and all that sort of stuff. Is there now a service out there that duplicates that PHaMs role?

Mr Frkovic: The federal government in its decision obviously like the state governments cashed out a lot of its programs into the NDIS. Obviously then there was more money put into the NDIS. The federal government at the time cashed out PHaMs, Partners in Recovery, day-to-day living and the carers measure. It was all cashed out into the NDIS. They did continue some support funding which is still continued. It has been going on and has just been extended by the federal government in the last budget for another couple more years, providing transitional support for those people who were in those programs. It is not recurrent; it is not ongoing. My answer is that programs such as that do not exist and potentially will not exist into the future in terms of what we had previously.

Mr O'ROURKE: You mentioned earlier that there are quite a lot of people with mental health issues who do not receive NDIS funding. That is quite frightening.

Mr Frkovic: Of course. Again, the Productivity Commission made a recommendation, from my recollection of reading the report, that in fact because the Commonwealth government is responsible

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for the National Disability Insurance Scheme the rest of psychosocial support should be taken up by the states and territories. That is a big ask if you think about what is really asked in terms of that support. There is a huge gap. In fact, Community Mental Health Australia said that really what is needed nationally to fill some of that gap, even at the severe end, is about $600 million annually recurrent, which means we would get 20 per cent of that. They are calling on the federal government to fund that.

Mr O'ROURKE: We did not have to be looking at that!

Ms KING: I have a couple of loose ends I would like to tie up before I move to a more substantive question. First, I am aware of the mental health cafe program. Can you briefly note your understanding of that and what we know about its value so far?

Mr Frkovic: If I am right, initially the Safe Spaces model was called Safe Space Cafe. Primarily it came from the UK where, for example, if you were in distress—some people do turn up to ED—rather than going to ED you could go to a Safe Space cafe, have a cup of coffee with a clinician, a peer worker, and work through some of the issues that are happening for you. These are those more informal options for people who might be in situational crisis but who do not need an ED or a hospital admission. We are rolling out about eight of those—and John might be able to confirm some of that—that the state government has funded. We are looking to expand those options across the state. I know the primary health care networks are also funding some of those. I see those as opportunities where people can go and get support. I certainly visited the one in Victoria to look at how it operates. It is really a drop-in place—picking up the member's point—where people can come. Because of the location in Victoria, it really attracts a lot of homeless people who will end up in ED but who actually come to the Safe Space cafe. I think we are talking about the same thing when you mention that cafe. It is really about sitting down and having a coffee.

In some of the ones in the UK, it is like a cafe really. You come in, sit down and have a coffee. In fact, one of them I saw had a couple of consulting rooms at the back where you could have a quiet conversation on the lounge with somebody. There are slightly different models. Some are totally peer-run. You come in and you talk to peers. Others have a combination of peer and clinicians. We have also seen some that are much more allied health, clinical-run. The model depends on what you have got in the rest of your architecture within your catchment area.

Ms KING: Are there any other stand-out programs, whether Queensland Health-run, NGO-run, federal government-run, that you would like to draw the committee's attention to?

Mr Frkovic: In any particular space?

Ms KING: Anything that you think is delivering that you want us to know about. You did mention pockets of excellence.

Mr Frkovic: There are heaps of pockets of excellence. We could talk about whether it was in housing, employment, health related et cetera, because there are pockets of excellence across the board. You heard about some of those this morning. We talk about the co-responder models. They are pockets of excellence that work and that actually produce. We need to think about how to scale and about how to make this. Even though people will say, 'They are expensive models,' look at the impact they are having. They are certainly good examples. There are some really great examples, picking up the theme around your cafes for example in the space of social enterprises. A great example is establishing social enterprises which employ people with mental health, drug and alcohol problems et cetera.

The state government and the federal government have contributed to funding social enterprises. Only recently the state government announced an investment in that. For example, the Vanguard Laundry in Toowoomba employs 50, 60, 80 people with mental health, drug and alcohol problems. They do all of the laundry work for local hotels et cetera. People get paid the award wage. It is like having a normal job but it is a supportive environment. Not only that, they have also used state government job readiness programs such as Skilling Queensland et cetera to help people transition into other jobs so they can provide support for other people to come into that program. It is a great example of what we could do better more in that particular space.

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When it comes specifically to mental health we have seen some good examples—I am sorry, I am going to speak to some of the work I did—involving the Floresco Centres in Ipswich and Toowoomba. Unfortunately, because of the way funding goes, even though we proved there were some clear outcomes in terms of presentations to ED and quality of life because there was not recurrent funding one of those centres closed. These were integrated models where the public, private and NGO sectors worked together. We have some great examples around the housing and support program. We have some great examples, as you say, in terms of the early work around the

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alternative to emergency departments. We have a whole range of things that we could certainly put on the table for consideration. I am certainly happy to put some of that up when I do my final submission.

It is not so much about examples but it is also about how we build a system. They are all pockets, they are like little islands, but how do we systemise that so people can get the support they need. As one fairly famous person who works in this space said to me—her name is Helen Glover—'I want to be able to come in like I go to Bunnings.' She said, 'I want to go to aisle 16 and get this and aisle 12 to get that and over there to get this. I want to then walk out and do my weekend project.' People want a service where they can get all of this and move on with their life, as she said.

They are critical aspects. As I said in my introduction, at the moment everybody is doing intake, assessment and triage and then everybody's intervention is a referral, 'Go and see Mr Bloggs down the street.' Unless we have the architecture clear and all of these programs linked so people can get the support they need at various points in time, we can have all the examples of innovation and best practice but if they are islands I am not sure they are going to help.

Ms KING: I am sure we would really welcome some more information.

Mr Frkovic: I will certainly do that.

Ms KING: I am particularly interested in the experience of older people in Queensland and particularly people in aged care. I represent the oldest community in Queensland. Something that is often raised with me is the near impossibility that older people in residential aged care find in accessing specialist mental health services and the impacts on them when their mental ill health is not recognised—the different ways it can present in older people and all of those things. Did the royal commission make any particular recommendations or do you have any suggestions on how this could be better addressed?

Mr Frkovic: The national royal commission into aged care certainly made some recommendations in this area. Probably the two major ones are about providing mental health services to people in residential aged care but also supplying mental health services to people who are living in their own homes in the community. That is going to be a combination of things.

That is certainly partially a state government responsibility but I think more so it is a federal government responsibility. John can give you figures. We certainly need aged-care psychogeriatric beds in Queensland from my understanding of it. That is for people at the more severe end of the spectrum that may need that. We also need more older person's mental health community teams, particularly at that severe end.

We also have to work out how our older Australians living in their own homes access some of the MBS opportunities that are provided. Hopefully you do not have to pay a gap but you may have to pay a gap if you are living in your own home. How do we get over this policy misalignment where you cannot get those MBS services if you are in residential aged care. I think that that is something that needs to be tackled and resolved. Why should I be excluded from getting services in residential aged care just because of the environment I live in? I should be able to access the services the same as anybody else. I think they are the two major issues. There are lots of things around aged care, but even the royal commission focused on those two areas.

Older persons' mental health across the board needs a lot more work and a lot more investment. We have an ageing society so we are going to have more people who require this. We have to think about how we grow the system across the board.

CHAIR: I have been thinking about how we monitor and manage physical health and have been trying to compare that with mental health. Parents know how to surveil their children for developmental stages and whether they are physically okay. Most parents will take their kids to the dentist not because their teeth are falling out of their head but to get them checked. Most young people moving out of home in their early adulthood years know how to keep an eye on their health. It is not that they have necessarily been taught but they have a general idea and know where to turn. Similarly, they will continue those good practices.

We have good practices in terms of early detection for a whole range of cancers that we have just embedded. I think about the Stroke Foundation and the fantastic work they do. I have done a lot of it myself. Do we have those systems where there is a capacity for a check-up of people's mental health? Do they exist anywhere? Is it something that should exist? You talk about the missing middle. How do we stop people moving from having the predeterminants of mental health issues to the next part of the spectrum?

Mr Frkovic: My personal view—and I am sure that psychiatrists will be able to add to this and correct this—is that we all have a predisposition to some sort of mental health challenges in our life.

PROOF

Usually the triggers are environmental—so a whole range of social and environmental issues that we experience.

We have certainly seen a shift in some of this. The federal government certainly talked about introducing a screening tool, for example, for children at an early age to try to screen for this. We do not have a checklist like you would with a health check. It is more screening to understand if something is happening at an early stage and how to deal with it rather than letting it get older.

The other issue is the physical health of people with a mental illness. People with severe, complex mental illness are probably going to die 20 years earlier not because of their mental illness but because of their physical health issues. Dr John Reilly said that was particularly so when it comes to things like some of the more psychotic disorders such as schizophrenia. People are more likely to smoke and engage with alcohol et cetera. There is a whole range of those other health issues.

I know that John and a number of people nationally have done some really good work around physical health and mental health. Not checks as such, but as part of the process that we do not just say, 'We are here to look after your mental health' and we do not focus on the person's physical health. Whether they are a child or whether they are an adult physical health is just as important. The work that is being done is Equally Well. How do we make sure that we provide a holistic response to people—we are not just dealing with one aspect of their issue but we are looking at their physical and mental health. They go hand in hand. There was an earlier question around Health and Wellbeing Queensland. Physical health and the work they do with young people in the broader community has such a major impact on good mental health outcomes.

It goes back to the point that mental health is not an island. It needs to work with physical health. It needs to work with housing. It needs to work with a whole range of other areas. We do not have a checklist. We have a number of screening tools that we use at different points of a child's development or for adults, but we do not have what we would have, for example, in some of the physical health areas.

CHAIR: Talking about environmental issues or situations that trigger, for me as life goes on more and more friends and family go through break downs of long-term relationships. That seems to be quite a trigger event for a lot of people both in terms of substance abuse problems and mental health problems. There does not seem to be a huge amount of support when there is an obvious trigger like that. I am sure there are others ones if I put my mind to it. Is that something that the system needs to be starting to look at? If people are going through specific events like the loss of a job et cetera, do we need to be trying to intervene at that point and say, 'You are probably predetermined to have some sort of mental health or alcohol or substance abuse problem, we now know X is happening so perhaps we should be intervening'?

Mr Frkovic: I agree. That is why I said in my introduction that a lot of the interventions are outside of the realm of health—employment or relationship counselling agencies that provide relationship counselling or other sorts of intervention. The family law court is another example. These are such important areas where you have to consider the mental health implications and impacts of whatever decisions are made. Whether it is about the loss of a job, whether it is about a relationship breakdown, whether it is about drug and alcohol you have to think about it.

The message I am trying to get out is that health cannot do this alone. We have to have those sectors and areas take on mental health in a serious way. In Queensland we are probably doing okay, but we need to look at our investment to be able to do this more systemically. With housing, corrections, police, ambos, child safety, youth justice—and I can go on—there are good pockets of things happening around mental health, but how do we scale that and make that much more available to more people across the state.

Dr ROWAN: I want to come to the alcohol and other drugs sector. As you know, I have been a specialist physician in addiction medicine for over 20 years. I refer to the role and function of the Drug Court in Queensland and the role they perform in trying to reduce harms associated with substance misuse. Have you got any comments or recommendations as to the Drug Court and how the model can further be enhanced or improved in any way to further assist with the reduction in substance related harm in Queensland?

Mr Frkovic: I think the Drug Court plays an important role at a particular phase in a person's addiction or associated potential criminal activity. I do not have the data in front of me, but we are seeing some good outcomes through that process. It has not just the court component but a whole range of health and other supports around those individuals to help them graduate and work through those issues.

DRAFT

I spent some time in the Drug Court watching proceedings because I wanted to get my head around that. It is interesting how the court system takes a very supportive role in helping people to deal with their addiction. If there is criminal activity it is about how they manage that. Sometimes the criminal activity is just because it is possession and use. We need to think about some of those broader issues. To me some of those issues are health issues.

I was quite impressed with the way the court deals with these issues and takes a holistic approach. The magistrate talked about this person's upbringing and where he or she got to and how well they have done in the last three or four months and building on that. I saw it as a very positive environment. I hear from time to time that it is an expensive model and it has a range of issues, but I think we have to weigh that up in terms of the outcomes. We need to think about the benefits of it. I certainly see the benefits of it. I see the benefit at a later stage.

When it comes to drugs and alcohol, I would like to see the system move forward. I have certainly heard from the Queensland community that we need to divert people who have a health problem. I will use the word 'addiction', which we normally do not use. How do we support people who have an addiction get a health response rather than a criminal justice response?

I think that is the crux of where we need to go when it comes to drugs and alcohol. That will help with the Drug Court and a whole range of things for people who get to that point. Can we intervene and divert people at an earlier stage through police and other means to get people into treatment? These people have a health problem. If you look at the data, particularly some of the good data that was done by the Queensland competition commission, 63 per cent—off the top of head; I hope I have this right—of court presentations are to do with simple possession use. If you think about the growth in the prison population, the largest growth has been to do with illicit substances—32 per cent. The Drug Court is at one end, but we need to provide supports for people who have a health problem which is an addiction—I not in any way suggesting that we go soft on drugs—and get them into the right treatment and support early.

016 **Dr ROWAN:** In relation to that component that you are talking about there, Commissioner, about diverting eligible people into health services—I am aware of the Queensland Illicit Drug Diversion Initiative and some of those people there—is the commission able to provide any expert advice about illicit substances and decriminalisation or legislative frameworks for those people and the outcomes for population based mental health approaches and about whether they have been successful, whether there are pros and cons, positives and negatives?

Mr Frkovic: Yes. I have been to Portugal, as you are probably aware, and looked at their decriminalisation of illicit substances. I could spend hours talking about what they have achieved. There are two things: Portugal has not become the drug capital of Europe which was predicted when they decriminalised all illicit substances. There are two other important factors. In Portugal it is still illegal but, if a police officer does pick you up for substances, where you will get channelled will depend on the quantity. For example, if you are a trafficker, supplier or manufacturer, you will go into the criminal justice system. If you have a small supply for your own personal use because you have an addiction, you will go to the dissuasion commission, which is a health commission that gets you into treatment and care.

The most encouraging thing that I saw, apart from the way it works, was this: the prevalence of substance use in Portugal over the 20 years overall has probably stayed pretty stable. What was the most important bit that I saw in the data was that for young people the prevalence of particular addiction started to decrease over these 20 years. The way that the young people were relating to illicit substances had an impact in terms of their utilisation and a whole range of issues which actually saw a decline over time. To me that was probably the most important thing that I saw.

I brought that back to Queensland and we had a discussion—and I have done consultations across Queensland around a new drug and alcohol plan in Queensland. From my own personal perspective, and because there is potentially a level of misunderstanding around decriminalisation—in the Queensland context, and to a greater degree in the Australian context, when you say 'decriminalisation' people think you are saying 'legalisation'; they are very different concepts—I think where Queensland is at diversion for us at this particular point in time is the best option. We need to divert people who have an addiction who are not manufacturers, suppliers or traffickers but who have a genuine health issue. We need to channel those people into appropriate health services.

Mrs McMAHON: I would imagine that the Portugal experiment requires a fully funded alcohol and drug placement—

Mr Frkovic: Very well-funded.

PROOF

Mrs McMAHON:—when and where required.

Mr Frkovic: Correct.

Mrs McMAHON: I was going to ask you some questions on suicidality in Queensland. Before I do, when I was speaking to you last we were talking about a co-responder model. You indicated in a response that there had been an evaluation of a West Moreton co-responder model. Is it possible for the committee to get a copy of that evaluation?

Mr Frkovic: Yes, I think so. I will try to get my hands on it. I am certainly aware of it.

Mrs McMAHON: Thank you. Can you take that on notice?

Mr Frkovic: I will take that on notice.

Mrs McMAHON: In relation to suicidality—I know we spoke about rates and determinants and factors for that earlier. In your mind, when someone attempts suicide or has suicidal ideation, does that mean they have a mental health issue? Does a suicide attempt mean that the person has a mental illness or vice versa? Where does that intersect?

Mr Frkovic: It is a little bit like the discussion you had earlier with Queensland Health around disability and mental health and drug and alcohol and mental health and where does one stop and one start? Not all people who die by suicide have a diagnosed mental illness. They might be under a whole range of psychological stress and distress but they do not have a diagnosed mental illness. On the other hand, a lot of people who do have a diagnosed mental illness may also attempt to take their own life. It is hard to say it is one or the other. It is a combination of all of those things.

Mrs McMAHON: I remember from a policing perspective whenever we encountered someone who had made an attempt—I probably would have been to hundreds—the first port of call was to take them to an ED to have them assessed because it was better to be safe than sorry.

Mr Frkovic: Correct.

Mrs McMAHON: I want to understand the back end of that process where someone is conveyed to an emergency department because they have made an attempt. I note in your submission that up to 25 per cent of people discharged after a suicide attempt are likely to make another one, and the highest risk time for that is within three months post discharge. What does that initial admission—I know it is not technically an admission in most cases. With that first presentation following an attempt, what does the back end service support look like as a case study almost? What should be happening to reduce the likelihood of another attempt? I note all the data you provided about how many there are and that for every one successful suicide there are 20 attempts.

Mr Frkovic: Even 30.

Mrs McMAHON: For this committee's awareness, what does it look like and what services are provided through Queensland Health and other support services? I know we have used the word 'referral' several times here. What should it look like and what does it actually look like in practice?

Mr Frkovic: I will say a couple of things just to set the context. Work done about three or four years ago indicates that 25 per cent of people who present to public health services, not specifically mental health—it could be to ED or a whole range of things—die within seven days following that presentation. The figure even looks more dramatic when you think about the fact that 40 per cent of people who died by suicide had contact with a GP in the last four to six weeks. People are presenting to some level and what the response is depends on the outcome.

Ms KING: Sorry. Was that 25 per cent of people who present with a suicide attempt then die within seven days? Did I hear that correctly?

Mr Frkovic: That was 2015-16 data. I think 25 per cent of people who presented to ED—that is my recollection—who are in that suicidal state et cetera died by suicide within the seven days. Forty per cent of people who presented to GPs would take their life between four to six weeks after that presentation. If you think that we have about 700 or 800 people in Queensland, that gives you a bit of an idea of what that number would be.

When it comes to those presentations, depending on where people present, but at the moment we have an option to support people who present with suicidal ideation who may not get into particularly Queensland Health services. There is a service called the Way Back Support Service, which is jointly funded by the Commonwealth and the state. That means that if you present in a suicidal crisis and, for example, you do not get admitted into an inpatient bed but you need follow-up—you are still at risk—you then get follow-up proactively. This is usually funded through the

non-government sector. It is called the Way Back Support Service. It is partially funded by the Commonwealth and partially funded by the state.

Mrs McMAHON: What does that follow-up service actually look like? Given that many people are being discharged into a transient lifestyle, how does that work on the ground for someone in that area?

CHAIR: Before you answer that question, Commissioner, for the benefit of *Hansard* I would like to acknowledge that Associate Professor John Allan, Executive Director, Mental Health Alcohol and Other Drugs Branch, Queensland Health has returned as a witness. Welcome, Professor. You are now free to answer as you see fit, Commissioner or Professor.

Prof. Allan: Just on a point of clarification for Ivan, on the 25 per cent dying, what that is is that, when you present, 25 per cent of the people who subsequently died died within seven days. Hundreds and hundreds of people present.

Ms KING: I eventually realised you were talking about completing suicide.

Mr MOLHOEK: So it is not 25 per cent of all people who present.

Mr Frkovic: No.

Prof. Allan: Twenty-five per cent of the deaths are within seven days.

Ms KING: Just to clarify, this cohort we are talking about is people who complete suicide; is that right?

Mr Frkovic: Yes.

Ms KING: They are people who complete suicide and 25 per cent of them had presented to an ED or similar within seven days before their completed suicide.

Prof. Allan: That is correct.

Ms KING: And then a larger portion again presented to a GP four to six weeks prior.

Mr Frkovic: Correct. That was a good point of clarification. I am testing my own knowledge of the data.

Ms KING: I was a bit staggered at the alternative interpretation.

Mr Frkovic: Yes.

Mrs McMAHON: We were asking about what does that follow-up, the Way Back Support Service, look like practically on the ground?

Mr Frkovic: You get a follow-up through an NGO. Within 24 hours is the first contact. Then it is face to face. Then it is ongoing depend on the level of need. It is about keeping the person safe and making sure they have links and supports in place whether it is other services et cetera. It is quite intensive in those first phases until a person is stabilised or linked into other services. It is funded through the non-government sector. They will employ a whole combination of staff—psychosocial support staff, allied health staff, peer workers even—who do that proactive, active follow-up of people who present with suicidal ideation but then get discharged to go home.

CHAIR: Do we have any statistics on the effectiveness of the program?

Mrs McMAHON: Has an evaluation been done?

Prof. Allan: We have some data. It is quite effective. I would have to take that on notice. We do have data about people making further contact and following through on what happens and some good outcomes. There are currently seven Way Back services in Queensland. They are jointly funded between the Commonwealth and ourselves. We are negotiating with the Commonwealth to put in many, many more.

Mr Frkovic: Do more of that.

Prof. Allan: They are very effective. We will make slight changes to the model to have more clinical liaison as well as the NGO. That is an example of good innovation that Ivan was talking about.

CHAIR: I think we have time for one final question.

Ms KING: When we get that information, could we also include where those services are located?

Mr Frkovic: Yes, we can.

Prof. Allan: We have a fact sheet for the Commonwealth.

PROOF

CHAIR: The member for Moggill has one final question.

Dr ROWAN: Again, Commissioner, just coming back to the alcohol and other drug sector, I noted your comments earlier about beds not being the be-all and end-all when it comes to service provision. In the submission of the Queensland Mental Health Commission they said there were significant service gaps in the alcohol and other drug clinical service system in Queensland particularly for vulnerable populations, whether they be Aboriginal and Torres Strait Islanders or those from culturally and linguistically diverse backgrounds. Does the commission have any specific advice around alcohol and other drug inpatient detoxification and rehabilitation units, apart from what already exists or is being planned in Queensland? Are they significantly needed anywhere else based on the feedback you have received from the sector and/or data that you are monitoring?

Mr Frkovic: I think my overall statement around the lack of funding for AOD overall really needs to be addressed. Within that there are certainly public sector beds that are needed, both rehabilitation and detox beds across the state, but also in the non-government sector. The scale is pretty large from my understanding. I do not have the data here. If we were looking at the planning framework for the drug and alcohol sector, that would indicate quite a large gap in inpatient services, particularly inpatient bed services, whether government or non-government, in the AOD sector. That would be in the hundreds.

CHAIR: Commissioner, I would like to thank you and your staff for presenting this afternoon. It has been a very lengthy exercise for yourself. I note a number of matters were taken on notice. The time frame for responding to those is by the close of business on 28 January. I would like to thank Hansard and the committee secretariat for their support today. It has been a very useful session. I would like to thank all of the members of the committee for engaging in the process and for asking good questions. I would now like to declare this public briefing closed.

The committee adjourned at 2.15 pm.

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