



MENTAL HEALTH SELECT COMMITTEE

Members present:

Mr JP Kelly MP—Chair
Ms AJ Camm MP
Mr RI Katter MP (virtual)
Ms AB King MP
Mrs MF McMahon MP
Mr R Molhoek MP
Mr BL O'Rourke MP
Dr CAC Rowan MP

Staff present:

Dr A Beem—Acting Committee Secretary
Ms M Westcott—Assistant Committee Secretary

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

TRANSCRIPT OF PROCEEDINGS

FRIDAY, 11 FEBRUARY 2022

Brisbane

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The committee met at 11.17 am.

DAWSON, Ms Jacky, Senior Adviser, Student Services, Independent Schools Queensland

MOUNTFORD, Mr Christopher, Chief Executive Officer, Independent Schools Queensland

O’GORMAN, Dr Shannon, Education Officer, Queensland Catholic Education Commission

PERRY, Dr Lee-Anne, AM, Executive Director, Queensland Catholic Education Commission

CHAIR: I invite each of your organisations to make a brief opening statement.

Dr Perry: In beginning, I respectfully acknowledge the traditional custodians of the land on which this meeting is taking place, the Turrbal and Jagera peoples, and pay our respects to elders past, present and emerging. Our comments today are on behalf of our five diocese and Catholic school authorities and 17 religious institutes and other incorporated bodies which between them operate a total of 313 Catholic schools that educate more than 156,000 students in Queensland.

Queensland Catholic education is founded in an inherent belief in the dignity of every person. Our school communities are places that seek to demonstrate inclusivity for all. From the outset, I acknowledge that mental illness or the diagnosis of mental illness does not define the abilities, relationships or contributions to be made by a student. Queensland Catholic education views student wellbeing as encompassing spiritual, psychological, physical, social, emotional, cognitive and cultural wellbeing. Catholic schools strive to create environments where students who experience mental illness are supported and, despite their illness, experience high levels of wellbeing.

Noting that suicide remains the leading cause of death for young people aged five to 17 years, QCEC recognises the critical importance of ensuring that schools strive to be places of safety where students are supported and help-seeking behaviours are fostered. Within Queensland Catholic schools, mental health and wellbeing are promoted through extensive pastoral care and service programs. Recognising the importance of a sense of belonging to one’s mental health, these programs seek to foster connection and engagement with the school and the broader community. Significant research attests to the mental health and wellbeing benefits of being of service to others so, in line with our Catholic mission, our schools support the broader community through such social and service programs.

In addition to these broader, proactive programs, QCEC acknowledges that specific expert support is needed for students experiencing mental illness. Catholic schools highly value the expertise of school counsellors and other professional staff who employ a triage model in which they provide assessment and, where appropriate and available, time limited interventions and/or referral to community health practitioners.

One of the challenges being experienced across the state is that demand for community mental health services is greater than the current capacity. As a result, school counsellors and the other professional staff in schools are dealing with an increased number of cases of significant and increasing complexity. Our schools also report difficulty in attracting and retaining wellbeing staff, most especially for our rural and remote schools.

As outlined in our submission, Queensland Catholic Education would welcome an expansion of the various funded programs, such as GPs in Schools, to include the non-state sector; continued funding to support students with mental health challenges; greater access to community mental health services; and consideration given to the recommendations of the Productivity Commission inquiry into mental health, including greater support for initial and ongoing teacher professional education.

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CHAIR: Thank you. I invite ISQ to make a statement.

Mr Mountford: Good morning, Chair and committee members. Thank you for the opportunity to be here. Independent Schools Queensland is the peak body representing Queensland's independent schooling sector. ISQ represents the interests of its member schools, fosters choice in education and protects the autonomy of independent schools. ISQ is a not-for-profit organisation and membership of ISQ is voluntary. It is important to note that as a membership organisation ISQ does not manage its member schools or impose directives on them. Governance around policies and procedures is carried out by individual schools. Over the past five years, enrolments in Queensland's independent schools have increased by more than 11 per cent, with over 138,000 students in our 231 independent schools across Queensland. That equates to about 15.5 per cent of the state's total school-age population and about 20 per cent of all secondary students.

Over recent years, independent school staff have been working tirelessly to address the ongoing challenges around the social and emotional wellbeing of their students and staff. I acknowledge the support of the state and federal governments in addressing these challenges to date; however, with mental health presentations continuing to rise within our school communities, we must also acknowledge that more work still needs to be done.

Schools are a reflection of the broader society and face similar societal issues, one of which is the increasing prevalence of mental health concerns. Similar to our state and Catholic counterparts, independent school staff report an increasing prevalence of students experiencing social and emotional difficulties, including students waiting for appointments with mental health clinicians. Some schools report long waitlists to access external psychologists, psychiatrists and paediatricians, with six to 12 months wait in some areas commonly reported. As an indication of the increasing prevalence of students requiring social and emotional support, from 2016 to 2021 the number of applications to ISQ from our member schools for state government funding for students who have been diagnosed with a psychiatric disorder and require significant educational adjustments increased by 138 per cent.

In 2021, the psychiatric disorder category comprised 10 per cent of all state funding and now it is the second most prevalent disability category in Queensland in independent schools, with autism spectrum disorder being the most prevalent. Similar to our Catholic colleagues, Queensland independent schools welcomes the Queensland government's \$100 million commitment to provide dedicated mental health coaches, allied health professionals and GPs in state schools across the state so that they can access the benefits of that increased wellbeing and mental health support. We note that this commitment is only for state schools and we would welcome its extension to the non-state schooling sector as well.

Consistent with schools in other sectors, our sector is also concerned about the wellbeing of staff, a situation that is further exacerbated by COVID-19. We recognise that staff wellbeing is important for student wellbeing and are doing some work and research in this space that we are happy to provide the committee. Again, school staff report being inadequately trained and supported to take on this additional responsibility with, at times, inconsistent responses from clinical service providers. Accessing clinical support for students following self-harm appears to be a particular concern for a number of our staff. Across our sector, our schools employ a range of different types of staff to support student wellbeing including psychologists, counsellors and social youth workers, for example. In response to the increasing support needs, many independent schools are reviewing the type of support services they provide and how they can more effectively provide those services.

I also want to highlight that within our 231 independent schools 35 provide boarding, with up to around 4,000 boarding students. These schools have the added responsibility of supporting students' mental wellbeing needs 24 hours a day while they are onsite. We particularly note that boarding students have been impacted heavily by COVID-19 over the past two years, with lockdowns and border restrictions limiting their ability to get home to visit their families throughout that period. That has had an impact on not only the students but also their families and their school communities.

I hope that the information we are providing you today highlights not only the growing need for support for students and staff in our schools but also the willingness of our independent schools to play their part in addressing this challenge as part of their responsibility to their school communities. However, we must not lose sight of the fact that this is a public health issue and, as such, cannot just be left up to schools. Greater support from all levels of government is needed to address this growing challenge across the community. We look forward to your questions.

Ms KING: Thank you for the work that you do to help deliver education to so many young people in Queensland. Traditionally, we know that frontline mental health support in schools has been at that lower acuity end, delivered often by guidance counsellors. Certainly schools in my electorate tell me of high rates of burnout for those professionals as they are presented with increasingly severe

and complex issues amongst the student body. In the course of this inquiry, we have heard significant submissions about what is commonly termed the 'missing middle'. You have the high-acuity services often delivered in hospital sites and the primary and low-acuity services that might include the kinds of care your school communities deliver. Have either of your organisations received any information about attempts by member schools to step into that missing middle and deliver support at a higher level of acuity, or do you have any further thoughts about how that support could be delivered?

Ms Dawson: I also respectfully acknowledge the traditional owners before I commence. 'Yes' is the answer, probably in some quite particular settings. There are some special assistance schools. It is a category of registration. Those schools generally look after students who are disengaged from mainstream settings, who have arrived in those schools with often some quite specific learning needs—sometimes undiagnosed learning needs—but also some mental health concerns. Those schools generally have a model where they have clinical support as part of those services. There is a tension, though. Schools can provide some of that clinical support, but it is not a replacement for having that ongoing support with community clinicians. Once they are no longer at school, or if they are not accessing programs—on a weekend, for example, or on the school holidays—making sure there are connections back to those clinical community services is a critical part of what they do. Yes, they do try and work very closely with the local CYMHSs where that is possible, and where a student comes in already in the care of a clinician they will endeavour to work very closely with them to try and provide that support.

Ms KING: I suppose I am thinking of schools as a site of delivery rather than necessarily the deliverer themselves.

Ms Dawson: Sometimes they do. There are some schools that have arrangements with a range of providers. The ones I am most familiar with are possibly psychologists, but there are also people like speech language pathologists. A school may have a commercial arrangement where they provide avenues for those people to be onsite. Where a student may have an NDIS package, for example, a school is able to, if they could come to an arrangement, provide space for that NDIS provider potentially to also work onsite. We would hope that those arrangements mean that there is a good connection between what is happening in someone's package or in the therapy being provided externally with the support then that a school could provide as well.

Ms KING: I wondered if either of your organisations had heard from your member schools anything around the crossover between those medical or learning diagnoses, perhaps ADHD and autism, and the mental health needs of students. Has that been flagged by your member schools at any stage?

Ms Dawson: Yes, it has with ours. We actually do see applications coming in from schools from the seven medical categories for which state government funding is available and, yes, we would certainly see through those ASD applications very strong reference to comorbidity around things like anxiety, for example.

Dr Perry: I endorse the comments that Jacky has offered. It would be quite similar across Catholic schools, particularly when you have visiting professionals come into schools. As we have spoken about before, connection and feeling part of a community is really important. The more you disrupt that the harder it is for the young person, so if you have external people coming in so that a child has to then go out of class, go out of the normal sequencing—it is difficult enough for young people to access in-school supports like the counsellor. There is a sense of 'I am seen as different'. Then you add to that external professionals coming in. It is a fine balance. The school day is quite short and I think it is really important that we are careful not to have too many disruptions to that, particularly to the most vulnerable students.

Ms CAMM: Thank you for being here. I have two questions to both Dr Perry and Mr Mountford. The first one is really actually just a yes or no. Without an increase in either state or federal funding, would you have the capacity to deliver a service similar to the state government's wellbeing program where we will see GPs, psychologists and other health professionals placed in schools to support students?

Dr Perry: I cannot give you a straight yes or no. Without funding support it would be very difficult. The only way it could be done is via another source of income, which is school fees, which means you are putting up school fees which, in effect, has an impact on the most disadvantaged communities.

Ms CAMM: Thank you for your answer.

Mr Mountford: It would be similar for us. I think more so it would vary school by school as well.

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Ms CAMM: I did forget to disclose, and I do not see it as a conflict, that my two children attend Catholic schools. We heard from our state agencies and education department previously. In communities—and I think of my own community of Proserpine as an example, where we have a Catholic school and we have a state school delivery—where we have a shortage of psychologists and GP services and all of those sorts of things, would it be a consideration of both of your organisations to work in collaboration, if it was a recommendation of this committee, to enhance government investment, whether that be state or federal government investment, for the wellbeing of children and young people to be able to provide accessible services that the current state government policy provides around wellbeing? Would that be something that your schools and organisations would be open to, particularly in regional and remote areas where we may see two schools, whether it be an independent and state school, but we see a shortage of those mental health services?

Dr Perry: Absolutely. It happens now. We have advisory visiting teachers for hearing impaired students and various other reasons and the human resource is shared across a number of schooling sectors. The model is already in place in some areas and it works extremely well, and clearly it just makes sense to have what is a limited resource available to all school sectors and for the funding to be extended to that. We would welcome that.

Mr O'ROURKE: Thank you for being here today. My query is in regard to boarding schools. In my region I have five independent and Catholic boarding schools. What strategies are in place to support our boarding students around their mental health and linking to services for that specific target group?

Dr Perry: It would vary from boarding school to boarding school. It is always constrained by financial resources, of course. Our boarding schools use a range of strategies. Boarding schools would have school nurses, for example, who are really important. I would like to emphasise that school nurses, where schools are able to have them—boarding schools generally do, and some day schools as well—are really important. Students are very comfortable going to a nurse and nurses are very attuned to the person before them. Nurses are a really important part of that. Then there is a range of other support—what we would call pastoral staff who engage with the young people on a more informal basis but being very attuned to the wellbeing needs of the young people. Then, of course, they would refer to other specialists and would draw on the school specialist staff in addition to that.

It is being attuned to the young people, how they are presenting in the boarding school and referring them to the appropriate agency. That is where your support workers, your chaplains, your student welfare workers, that sort of team—it is that whole-of-community approach, which we would see as really important. We also engage our boarding students, as I referenced in our submission, in a range of service activities. They are going out and connecting with others in the community. It is often through those programs that students are more likely to, I guess, be more comfortable in sharing how they are feeling and then you can pick that up, because part of the issue, of course, is always identification and students feeling comfortable in a trusted other appropriate adult.

Dr ROWAN: Thank you to representatives from Independent Schools Queensland and the Queensland Catholic Education Commission for being here today. The first question might have to be taken on notice, but it is just following on from the member for Whitsunday in relation to that Student Wellbeing Package for the non-state school sector, just a dollar figure of what that would actually be. If you are able to advise now that is fine or, alternatively, I would be happy for that to be taken on notice.

CHAIR: Are you happy to take that on notice?

Dr Perry: Yes, otherwise it would be an ambit claim on our part. You probably do not want that.

Dr ROWAN: I thought that might be the case. My second question is with respect to mental health first-aid training that occurs for teachers to be able to support students with a range of mental health conditions. Can you outline what is happening to date in the independent schools sector and advise any additional supports, funding or work that could be done to enhance that, given what teachers are facing not only in the non-state school sector but also in the state school sector?

Dr Perry: If I could refer that to my colleague Dr O'Gorman, who until very recently was working in a school as a school counsellor so has hands-on experience as a practitioner as well as in the policy space.

Dr O'Gorman: I would draw attention to the fact that some of our Catholic school authorities engage with youth mental health first-aid and teen mental health first-aid within their schools so they are taking that approach from staff to a peer based model. I would also comment that the state has a wonderful resource at their disposable—STORM training—which is offered through Be You and headspace, or the headspace Schools Program, which is something that I guess our sector would

very much value having in the future as well, because it is quite specific and targeted at upskilling parents through to teachers through to leadership and then, at the top end, your guidance counsellors in the specific understanding of early warning signs and risk assessment.

Dr ROWAN: What would be needed to make that a reality in the non-state school sector?

Dr Perry: Access to the program. For them to be funded so that it is accessible to every student in every school in Queensland.

Dr ROWAN: Just moving on to social media platforms, I have been, like all elected representatives here and the broader community, very concerned about the numerous examples of mental harms we have seen with respect to bullying, harassment and intimidation, particularly amongst young people, and those adverse consequences. Would you have any recommendations as to what can be further done to deal with this? Is there any specific legislation that is needed in Queensland to tackle that particular issue and what it means for students here in Queensland?

Dr Perry: It is clearly an ongoing issue. I was fortunate to be part of the Premier's Anti-Cyberbullying Task Force a few years ago so heard from people across the state. It is clearly an issue of concern. I would feel a legislative response is probably not the most ideal. It is around working at every level in schools. Students are less likely to be impacted by issues of bullying if they feel a sense of connection. Often those who perpetrate bullying feel in some way alienated, disengaged and so on. It is working from the grassroots and building that systemic approach in schools. That requires, of course, training and the resourcing in order to provide the training in terms of both the programs and the time for teachers to do that.

The online area just has exacerbated issues which have been in schools since time immemorial, as we all know, but it is 24 hours a day. It also requires, I think, a much greater emphasis on upskilling our parents. Because it is 24 hours, a lot of it is happening at home. Schools can do so much and are really important, but we need to be working with our families as well in terms of the strategies parents can put in place. I would see it is more around the resourcing of the training of people in schools and families working together and then working with young people, because young people—again, it is giving them agency in order to work together, because peers are often the most effective in terms of helping to stop it happening and also helping to support those who are affected.

That is a bit of a long answer, Dr Rowan. We have extensive legislation. We have, I think, the legislative tools for schools to act where cases are extreme, but I think it is around that ongoing systematic and sustained support for schools on every level—students, staff and families—because that is the only way I think we will ever actually make some inroads in this area.

Dr O'Gorman: Some young people are fortunate enough to have access to psychologists, to GPs, to psychiatrists. Those young people with anxiety disorders, with school refusals, with autism spectrum disorder, who access those services will often report to those providers their experiences of being bullied. What we would find is that those providers are not funded to then consult with the school and provide the school with the strategies or the feedback or the upskilling of the teaching staff. Perhaps, as we have put in our submission, those professionals having a Medicare item number that would allow them to consult with the school would ensure that feedback loop is provided between the health sector and the school education sector.

CHAIR: I was under the impression from the QCEC submission that teachers are actually accessing the SAFEMinds and STORM programs; is that correct?

Dr O'Gorman: We do not have the funding to access that. Whilst one of our Catholic school authorities has managed to access some additional funding that they were able to use, sector wide we do not have that access.

CHAIR: In your submission you talked about the Productivity Commission recommendations and you noted that there has been some work done on data gathering. You also noted a lack of accreditation of SEL programs and standardisation of SEL programs. Is there any similar work being done in relation to trying to standardise SEL programs and, if there is work being done, what stage is it at? That is a big sigh, Dr Perry.

Dr Perry: Yes, sorry, it is a sigh. This is a really problematic area. Schools are working really, really hard in this space. There are lots of providers out there and their programs might look good, but the evidence base underpinning them is very, very patchy and so that is an ongoing issue. We had the opportunity a couple of years ago to get academics from Griffith University to do a quick review of our programs and they pointed out to us, 'Well, these ones have a strong evidence base. These ones have almost no evidence base.' It is about making a strong evidence base available to every school so that we are not wasting time and effort and resources on things which do not have a strong evidence base.

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Work is happening. We are doing some work in our sector. I am sure the independent schools are. It is happening interstate and it is happening nationally, but it is not well coordinated and I think that is what the Productivity Commission was referring to. There is a lot of effort going on, but it is not really being well drawn together. There is work being done in terms of data capture, so 'how do we measure wellbeing in schools?' There are various measures out there, but, of course, they are not consistent so it is very hard to get appropriate benchmarking. It is an area which cries out for a national coordinated approach or, if we cannot get that, at least a state coordinated approach where we can give schools opportunities to choose, so that they can say, 'This is most appropriate. Here are some which we know have a really strong evidence base. Here is a survey tool'—which will be, again, evidence based—'which will enable you to take some benchmark readings to compare yourself with other schools so that you can actually get a genuine sense.'

CHAIR: Would the SEL area be where you might introduce some of your curriculum around mental health and do some of that work around resilience and how to monitor yourself for developing problems et cetera?

Dr Perry: That is happening now. As I said, I think the efforts are dissipated somewhat because of the plethora of programs that are out there. Efforts are being made to try to narrow that down to make them evidence based, but in my view it needs to happen a lot faster and our efforts need to be coordinated much more effectively. I would love to see Queensland be a leader in this space—that the government and the parliament supported an investment in these really good programs and made them accessible to everyone. We know that there is evidence to support them. Then the schools would choose appropriately for their school context, with some survey tools to help.

It is very hard to know at times whether the prevalence in your school is high, low or anything in between. Obviously, there is NCCD, and we have the education adjustment programs and so on which pick up some data, but as we know there are lots of students who are not picked up in that. The question then is: how do we pick that up so we can intervene very early?

CHAIR: I was impressed with the notion of service that you mentioned in the submission. I know from the Catholic schools that I had experience with growing up and also the ones in my community that service is very much embedded into the school community. You mentioned that there is data around the positive impacts on wellbeing and mental health. Can the committee have access to that data and the research that you have? Are you able to provide that?

Dr Perry: We will get that to you if we can provide that data.

Mrs McMAHON: I disclose that I too have a child who attends collectively one of your schools. Having said that, as a mother of a non-binary student and as a mother of a student with a disability, specifically an ASD spectrum where anxiety, behaviour and lack of social skills is quite prevalent—and I shudder to think what my youngest will bring to the table as she gets older—when we go around and select the appropriate school for our children, can you speak to the inclusiveness that your school communities can provide, noting that my children are inherently vulnerable to mental health because of their various characteristics? It may not transpire, but I know that they are at higher risk than most other children. I know that your answer will be general because each school is quite different. What are some of the inclusive policies and procedures that your schools have in place to assist a parent in deciding the most appropriate school for their child?

Mr Mountford: I will get Jacky to speak to the specific policies and issues that some of our schools have in place. I think in our sector what is important to say is that that is why we believe in the need for choice and diversity across the whole schooling sector, so that parents are able to make that decision about the school that best suits their family's needs and their child's needs and are able to make that decision in their best interests. Across our sector, we have a vast variety of different schools—from very small to very large—which have a particular education ethos or a particular faith based ethos, so the policies and procedures of those schools will reflect those types of approaches that they have. For us, it is about the school being transparent and open about that and ensuring that parents in a school community can make that decision in a really informed way. Jacky might have additional comments.

Ms Dawson: In a broad sense, the disability standards for education are that the federal legislation provides the basis of what all schools are expected to do in terms of enrolling and providing support for students. We would encourage our schools, as we do very strongly in the training that we do, to be able to get good information from students when they are enrolling them so they can look at how they can meet their needs in the best possible way. Certainly, all schools in the independent sector have a very strong focus on that pastoral support. It is not just about the academic support and it is not just about a label for a disability; it generally is, 'This is the young person, this is what we are seeing, this is what they need and this is the best way we can provide that.' That is the approach that we would ask our schools to use.

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Dr Perry: If I can speak from the Catholic sector, and as we put in our submission, our schools are premised on the respect of the inherent dignity of every child—every child. All of our schools are committed to inclusion of every child to the absolute best of their ability. That is the starting premise. Our schools are structured around a pastoral approach that is embedded. At a primary school, the teacher in the class is obviously the unit. In a secondary school, there are a variety of structures. If I speak from my own experience at a big secondary school, they have a house system where a student is in a small pastoral group so they have the same person seeing them every day. They are part of a house which they stay in throughout their time so that they know the students in that group, their siblings are in that group and so forth. It is inherent to all of the structures, processes and policies of the school.

Our schools have worked really hard and, to be honest, they have got much better in terms of inclusive practices at a really fundamental level. The school uniform is one, and I think we have come a long way in terms of ensuring that school uniforms are inclusive of all young people—whether they want to be active, passive or whatever it might be. I think that is what schools are constantly working towards—to ensure not only that your overarching mission and values are quite explicit but how that is then enacted in every policy and procedure within the school. I am not suggesting that we have got it perfect and that it is perfect in every school, but I think there is a really great focus on how to ensure that every young person in all of their diversity feels welcome, included and supported.

That is an ongoing thing, because we have a society which is very quick to pick up on difference and to use difference as a point of attack. As schools, we need to be educating young people around this. We actually need to celebrate diversity and support that diversity and see that we are all enriched by that diversity. That is what schools are fundamentally about—that is, educating young people, not just in terms of the academic curriculum but also in terms of their engagement as members of society and the community the school is part of and then the broader community. I think we are working very hard. I think we have come a long way and we will continue on that journey.

CHAIR: The QCEC submission talks about the need for counselling services, particularly in relation to suicide and self-harm, being delivered in an appropriate time and an appropriate manner but you also mention challenges around workforce issues. What is the key issue? Is it a need for more staff and services, is it a need for action on workforce so you can deliver what you are currently trying to deliver, or do you need a new model of service delivery?

Dr Perry: I think it is actually a range of things. It is an area where there is never enough. There is a growing need and demand for both, in a sense, reactive processes—so dealing with young people as they present—and proactive. That, again, is a tension in schools. We have our highly qualified staff who we want to be doing both. We want them to be working in terms of proactive strategies—how do we upskill our young people and so forth—but often their time is fully occupied with responding to the presentation of young people, with particularly acute care. While the ideal is that you triage—in terms of referring them out to other professionals—it is about getting access to those other professionals, and I think Shannon can speak to that. Certainly, it is an area where we need more support.

There is a need for ongoing training—from initial teacher education through to ongoing professional learning—because a lot of work begins at the coalface, at the classroom teacher, whether it is in a primary school. More and more, we are getting presentations in primary schools, which is the other thing to be very conscious of. This is not just a secondary school issue. We are getting presentations of quite significant mental health issues. They are not to the extent of the older students but it is an issue. Again, our resourcing models need to reflect that. I think it is both of those. Shannon can add some more.

Dr O’Gorman: We are trying to draw the same talent pool across Health, Justice, Child Safety, Education. These are all people who are social work qualified, psychology qualified, who are trying to help young people. Then you add in private practice, and we know that the government last year added in 10 extra sessions under the Better Access to Mental Health Care plan. That is fantastic, but it draws out practitioners into private practice models. It is hard for particularly our rural and remote communities to staff their schools because those staff are wanted across the board.

Dr ROWAN: I might direct this question to Independent Schools Queensland but I am sure the Queensland Catholic Education Commission may have some comments as well. Given the circumstances of the COVID-19 pandemic over the last two years, are there any trends that ISQ is seeing with respect to mental health or issues in relation to students, teachers and parents? Given ISQ represents that sector, what are the trends that are being reported back to you as an organisation from member schools across Queensland amongst students, teachers and parents?

Ms Dawson: Yes to all three is the answer. In my experience, I work very closely with a particular cohort of teachers in schools, and that is learning support. They are the people who are managing whatever the difference is and the support for students. I would have to say that I have never seen them as stressed as they are. It is not just young, inexperienced staff; those who are established in their schools and are well into their careers are really struggling. They are similarly reporting that students themselves are struggling.

We have seen lots of additional reports in applications that we are seeing now that are different from what we were seeing last year—particularly ASD, which is about 66 per cent of the applications that we receive. There is an increasing prevalence of people reporting anxiety, school refusal and a whole lot of things. Parents themselves are being very concerned. Where school refusal is an issue, it is not always being driven by the students themselves. Sometimes it is parents similarly not being concerned about having their children back in the school environment. There is no doubt anecdotally from what we are seeing that there is increasing anxiety with students, their parents and absolutely with teachers in terms of the workload and having to pivot to online and then to online and face-to-face and whatever that looks like. It has been a huge emotional toll and it continues.

Dr ROWAN: I want to ask ISQ about how the non-state school sector could be further engaged in improving mental health literacy amongst not only Queensland students but, again, the broader community. There are numbers of independent schools which are in small communities in rural, regional and remote Queensland so I am interested in the role that can be played by them not only for students but for the broader community as well.

Ms Dawson: It is interesting that you should talk about that, because ISQ has a parent network. We actively reach out to parents as well. We would see that that is probably a good place that we could provide—and we do provide—support. We are fortunate that we link, as do the other sectors, to Ed-LinQ with Queensland Health, to headspace for the services that we can get and to the national Be You initiative, which does a lot of work particularly in the promotion and prevention space in schools. We offer professional learning through our parent network already. I am aware that some schools offer a portal—I will not name them because my knowledge is a couple of years old—of online professional learning and access to all sorts of information that they routinely provide to their parents. They see themselves as understanding that parents are key partners in keeping students well.

Dr Perry: We talk about parent engagement being a really critical aspect and involving a lot more work. It is very cost-effective in a sense. In trying to deliver that, there is always that overlay that regional and remote is a particular challenge. One of the things about COVID is that, while there have been pressures brought by COVID, we have learned a lot of effective strategies to deliver learning of all different sorts remotely. We should not lose some of that great expertise that we have had, both in terms of learning for parents and learning for school communities and in terms of access to professional services, so that we better harness that.

It probably goes also to the chair's question earlier about different resourcing models. That would be one area of state supported access to professionals or to programs which anyone can access—and it is just-in-time learning, because traditionally programs for parents were at a set time on a set night. That just did not work. One of the great benefits of COVID—and I am sure those who have children would know this—is that parent-teacher interviews went online and parents said, 'This is the best thing we have ever had, because it accommodates family circumstances.' Using remote technology and the expertise—high-quality input and engagement through remote technology—would be great.

In terms of resourcing, I mentioned nurses. We tend to go to the GP or the psychologist. There are a range of professionals who can provide different levels of support, and I think we need to be more creative in schools. Rather than the traditional staffing structures we have had in schools, I would like to think we could be much more creative and flexible around that range of professionals and paraprofessionals who can support our schools.

CHAIR: On that note, I thank all of you for your presentations today. It has been very useful for the committee to build our understanding of your important sectors. I thank you all for the work that you do and I thank the many people who make up your sectors for the work they do for Queenslanders. You did take some questions on notice. Could the answers to those questions be returned by 18February.

Dr Perry: Thanks, Chair and committee. Thank you for the opportunity.

Proceedings suspended from 12.03 pm to 12.15 pm.

DENNY, Dr Simon, Director, Mater Young Adult Health Centre

McGAHAN, Mr Greg, Senior Manager, Young Adult and Mental Health Services, Mater Young Adult Health Centre (via videoconference)

SCOTT, Professor James, Group Leader, Child and Youth Research Group, QIMR Berghofer Medical Research Institute

STATHIS, Associate Professor Stephen, Medical Director, Child and Youth Mental Health Service, Children's Health Queensland Hospital and Health Service

TRACEY, Adjunct Professor Frank, Health Service Chief Executive, Children's Health Queensland Hospital and Health Service

CHAIR: Welcome. I invite each institution to make a very brief opening statement and then we will move to questions.

Dr Denny: I start by acknowledging the traditional owners of the lands upon which we meet and their strong connection to the land and geography and their elders past, present and, especially in my case, emerging, as they are our future leaders. Thank you for the opportunity to present today.

Just a bit of background: I am an adolescent and young adult physician. I have had 20-plus years clinical experience working predominantly with young people between the ages of 12 and 24 and also had quite a lot of experience in research and academia and published over 150 reports, papers and that sort of thing.

It was the Mater Young Adult Health Centre in Brisbane that brought me from New Zealand three years ago because it is unique. It is a world-renowned facility that provides health services to young people aged from 16 to 24. I will quickly go through what that looks like. We have a medical and surgical ward for young people. We have outpatient clinics where we see 500 young people per month. We have a statewide drug and alcohol service for young people from 13 to 25 that does withdrawal, rehabilitation and evaluation as well as drop-in and outreach. We have a private emotional health unit—the first of its kind in Queensland—specifically for 16- to 24-year-olds. That is a 12-bed unit. That is a private facility. We are the first teaching and training site through the Royal Australasian College of Physicians for people like myself.

You might be asking what an adolescent and young adult physician is. I am a rare breed in Queensland. I was the only one but there are two of us now. We bridge the gap between physical and mental health issues. Half our training is in the area of mental health. This is a recently recognised area of specialisation within the Royal Australasian College of Physicians.

I will give you a flavour of what I have seen in the last week in my clinical work. I saw a young man in his early 20s who has been having recurrent collapses for the last 15 years of his life. Unfortunately, he had dropped out of medical services and was not put on the appropriate treatment. After I got him started on treatment those episodes completely vanished. Those episodes were causing extraordinary mental health problems. As you can imagine, if you are collapsing several times a week it is very hard to engage in training, education or employment.

I have also seen a young woman on the ward who has diabetes. When I first met her she was presenting almost every other week with diabetic ketoacidosis. Recognising the extensive trauma history she had and providing holistic wraparound care, we have been able to avoid most of those admissions in the last year or two.

Finally, I saw a young man in our drug and alcohol service who had been homeless and just made a diagnosis of scabies. Part of the reason he was able to access care was that it was low cost—that is, free.

My world is as a generalist, but I try to provide holistic, team based and integrated care. I might hand over to Greg to talk more about some of what we see as the major mental health issues for young people in Queensland.

Mr McGahan: Thank you, Simon. Thank you to the committee for the opportunity to speak today. Unfortunately I cannot be with you. I have tested positive for COVID so I am, like many other Queenslanders, stuck at home in isolation at the moment.

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I am a mental health nurse and I have over 30 years experience, mostly in adolescent and young adult mental health. I have managed three mental health units in Queensland for adolescents and I have been involved in commissioning two of them. I have worked at various times with most of the panel here today. For the past six years I have been involved in establishing and running the Mater Young Adult Health Centre.

Firstly, I would like to advise the committee that, while we are focusing in our submission today on young people's mental health, Mater has a range of other mental health services, particularly where there is an unmet need in the community. We have also provided submissions to the committee on intellectual disability, mental health and perinatal mental health as Australia's largest maternity hospital. To that point, Mater has also extended an invitation to the secretary for you to visit and see our mental health services and specifically what we are doing in the perinatal space.

With regard to the submission today and following on from Simon, it is important to highlight the areas where we see young people are not able to access care and why that is problematic. I note that the Queensland Mental Health Commissioner talked about the missing middle. Adolescents and young adults certainly fall into that gap, particularly young people with moderate mental health concerns and internalising disorders, young people with co-existing alcohol and other drug concerns, disabilities and chronic diseases, young people leaving care, young people who are homeless or even young people without someone to advocate for them to help them manage the system and young people transitioning from child and youth to adult mental health services. This in itself is a systemic driven determinant of poor mental health outcomes for young people.

It is a particular problem for young people because they are falling through the cracks and are having to wait until a crisis. It is not ideal and does not make sense when treatment at the mild to moderate end of the spectrum is more effective and costs far less. All this is happening at a time when you are most likely to develop a mental illness. Suicide is the leading cause of death. The impacts on the young person's educational, developmental, employment and social trajectories can be devastating.

It is for these reasons that the young adult centre has varying degrees of mental health support built into all of our services and programs and why we have established Queensland's first private adolescent and young adult mental health service.

Dr Denny: The main issue that we see is the fragmentation of care. We see fragmentation between child and adult services. We know that a lot of young people drop out of services in that transition. We see a gap between medical services and mental health services. In my world, there is an 80-20 rule whereby with our medical services probably 20 per cent of young people make up 80 per cent of the work. That is due to underlying mental health problems. The final fragmentation is between health and the wider community, especially education and other community services. This leads to multiple fragmentation and multiple providers. In New Zealand, where I am from, we talk about multiple cars in the driveway. You can have three or four agencies driving up to one household, each providing their own care and unaware of what the other people are doing.

Our solution is around integrated health care—the co-location of services in one place where young people can access these sorts of things easily. A lot of the work I have done in New Zealand is around school health services. That is a great example of where, if you get it right, it can provide substantial improvements in young people's care. I remember when I was embarking on this work about 15 years ago visiting one of our exemplary school health services. We were thinking about KPIs for that service across Auckland. One of those KPIs was referral to mental health services. I remember the team leader in that service saying to me, 'That is completely the wrong KPI.' From their perspective, a referral out from the school health service meant that they had failed. A good school health service, by integrating teams alongside their education providers, means that we do not have to refer on to specialist services. That model requires onsite health professionals for most of the week. What we know is that visiting health professionals in school services just does not work. We are very much keen on services that are co-located in the community. To that end we are working on a youth foyer, which is supported accommodation that we are going to be having on the Mater precinct.

The other plea I would make is for more appropriate youth health services in hospitals. It has been fascinating coming to an adult hospital as a paediatrician. In the paediatric world at least, teenagers make up 50 per cent of your population. In adult hospitals they are probably less than 10 per cent, but they are still there. One of the most simple and cost-effective things the Mater did was simply co-locate those young people in one area. Then the magic happens. Then we can start wrapping around appropriate services and group programs that those young people really start to

thrive and shine in. It is the simple act of co-locating young people so that you start to develop specialist teams that wrap around those sorts of services. To that end, we think there is a huge need for more medical specialists in this area alongside youth psychologists and social workers who have expertise in this youth population.

CHAIR: We will move on to Children's Health Queensland.

Prof. Tracey: I, too, would like to respectfully acknowledge the traditional custodians of the land on which we are holding this conversation today and pay my respects to elders past, present and emerging.

Thank you so much for the invitation to speak with this committee. I really do appreciate it. I wanted to personally acknowledge your commitment as individuals to each and every one of your communities, for the way that you are seeking to improve how we invest in and care for communities across Queensland. This conversation around how we construct and deliver mental health and addiction services to children, young people and families is a critical conversation for our state. The eyes of the world will be on us from now until 2032. We have a unique opportunity.

It would be remiss of me not to acknowledge the work of our mental health and addiction staff—the workforce—throughout Queensland, particularly over these past two years. They care for children, young people and families every single day. It has been a difficult two years for everyone, but those staff are not only making an investment now to deal with those issues that are proximate for young people and families but also are investing in our collective future. My narrative today is around looking forward to a system approach that allows us to get the very best out of what it is we are currently doing in Queensland and to make sure that we have wise and constructive investment in moving us forward.

When I am referring to children and young people I am thinking about that perinatal period before they even arrive in the world and that zero to 25 population. Why I am referring to that continuum—that age span—is that there are specific markers and milestones over that life span that it is critically important we get right. The experts today on this panel and the experts who have spoken previously will talk to you in more detail about the nuances of that.

I also want to highlight the need for us to truly commit to an equity agenda for our First Nations children, young people and families and for those children and populations who aspire to equity and find it challenging to access appropriate services close to home.

Research over the past 30 years tells a consistent story. What it says to us is that if we invest in the concept of prevention and early intervention we will eventually reap the rewards of that. That is not to say we should not be making parallel investment in dealing with chronicity and the challenges faced by people every day. That focus is critically important. I am advocating for considered investment in the mental health of children and young people. I think it makes sense, not only from a health perspective but also from a social perspective and from an economic perspective.

Briefly, Children's Health Queensland is the lead HHS for the delivery of child and youth services, including child and youth mental health services, in this state. We provide child and youth acute inpatient services at the Queensland Children's Hospital. We have beds there and we work with our colleagues at the Mater in the delivery of those services. We have beds for children up to 14 years of age. It may not be any surprise to you that we see very young children with very serious presentations. We are fortunate in Queensland that we have that core, that heart, where we can actually take families and that child into an inpatient setting, deliver care there and then support them when they go home with appropriate services. I mention that because mental health is challenging and it is complex. No single agency has all of the answers. I am saying very firmly that we need a systems response. It needs to be an integrated response and we need to think about the policy context that allows us to do that and sometimes forces that function.

Children's Health Queensland has provided a 36-page report to this committee. I do not propose to go into the detail of that today. This has been via the mental health branch. I will ensure that this committee has visibility of that. I know that you have heard and will be hearing a wide range of perspectives from experts. They are nationally and internationally recognised. I do think, though, that it is beholden on me to state that Queensland punches above its weight internationally. We have some extraordinary examples of innovation around our service delivery in this particular area. Today, hopefully some of your questions to Dr Stathis and others will illustrate some of the examples of that.

I conclude, really, talking about fierce advocacy and how that is so critical to the formation of enduring and lasting relationships that are networked across this state. At Children's Health Queensland we are as concerned about the mental health and wellbeing of a child in Mackay and the Brisbane

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Torres and Cape as we are about children in the south-east corner, in Logan and beyond right down to the Gold Coast. We work through a very networked approach that is clinically led and driven and is governed tightly around how we deliver those services. Are they perfect? No. Can we do better? Absolutely, yes. We must strive to do that.

I wanted to assure this committee, and you, Chair, that government investment in mental health services has been substantial over recent years. It will be our great pleasure to host you at Jacaranda Place, an adolescent inpatient mental health centre—again, another first in Australia in the model of care and the model of delivery—designed with the Department of Education and delivered with the Department of Education, that provides care and support for young people when they need it most and then supports them to go back to their communities and stay connected, as Dr Denny has said, to their natural supports—their friends, education and life in general. I understand that the committee will be visiting next week.

Finally, can I say that I have certainly learnt a lot of lessons from COVID. I wanted to recommend that the committee consider how, when our backs are against the wall in Queensland, we have the fortitude and we have the foresight to work collaboratively and collectively, to work across policy boundaries, and to turn policy to implementation within 10 hours right across this state. For some examples of that, I think about how we have engaged with Education, Justice, the police, our primary care colleagues, the non-government sector, Indigenous organisations, schools at a local level—and the list goes on. We have had a centralised framework and a policy rapidly translated into action. We are doing that now, as we speak. We have been flexible. We have translated that at a local level into actions that support local communities and their specific needs.

The central tenet of what I want to leave you with for my introduction is that we have the ability here to meet local needs if we can provide the infrastructure and support through policy and funding mechanisms that allow that flexibility and allow local communities to draw on the oasis of resources available to them. Those relationships with schools, colleagues from Education, Justice, police, the mayor's office and the local council all exist. Through this COVID pandemic we have seen the agility that we have been able to draw on at a local level.

Finally, I pick up on a comment that was made earlier by Dr Rowan. One of the things we have really learnt in this pandemic is how to harness digital media. Our communication and our social media has been outstanding. We have delivered virtual care in virtual hospital wards. We have delivered hospitals in the home for a pandemic. We have done that rapidly and safely. In Child and Youth Mental Health Services we are dealing with what I call 'digital natives'. No longer are young people reaching to their local newspaper for their information; they are using their cell phones. They are using the internet. We need to harness that if we want to lift health literacy, if we want to support families. I believe we can use the digital media and the digital economy to really help us advance this agenda to think statewide and deliver locally to local populations. Thank you.

Prof. Scott: Thank you for the opportunity to speak today. My expertise is in young people with serious mental disorders, particularly psychosis. I am a researcher at QIMR but also am a director of the early psychosis service at Metro North. I wanted today to share a story of something that happened last year whilst I was on call at the Royal Brisbane hospital. On a Sunday afternoon in September, I got a phone call from a doctor in the emergency department. A young person, year 12, about to sit their ATAR exams had been sitting there with their parents for about five hours. He had not gone to school for a couple of weeks. He had been experiencing paranoid delusions for a few months and had really been unable to concentrate and focus on his schoolwork. He was heading towards, after 12 successful years at school, missing out on a final ATAR score and missing out on going to university, looking at lifelong disability as a result of a serious mental illness. The doctor on called me and said, 'He's psychotic. He's suicidal. We need you to meet him but the parents do not want him in a general adult hospital with all those older people with chronic schizophrenia.' I said, 'Look, send him home. My early psychosis service will see him tomorrow.' We saw him several times a week for the next few weeks and got him the right medication. We liaised with the school so he was exempted from the ATAR exams. He managed to go to Schoolies Week that year. He managed to get an ATAR exam. He is now back doing his activities. He now has a part-time job. He is starting university next week and going to O Week. This is the difference that mental health services can make to young people if they are properly provided.

The problem we have in Queensland is that that young person was lucky. He was lucky that he happened to turn up on a day when an expert in youth mental health was on call. He was lucky that he lived in a catchment area for a service that has a specialist early psychosis service. If he lived elsewhere in Queensland, he would have been placed in the adult mental health ward with 30-, 40- Brisbane

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or 50-year-old people with chronic mental disorders. He would have probably gotten placement medications that would cause weight gain and other problems. He would have probably never finished his schooling because they would not have liaised with the school. He would now be sitting at home wondering what he is going to do with the rest of his life.

We need to get excellent services for our young people with serious mental disorders. There has been an overinvestment in this country in the mild to moderate disorders. It is opposite to what you are hearing, but we are actually overservicing people with mild to moderate mental disorders. We are doing 20 sessions for stuff that should fix up in six sessions. If it is not going to fix up in six, it is not going to fix up in 20.

We need to get specialist youth mental health services so that people can step up their care and get the care they need, just like we do for other serious health problems. We do not keep pushing them on. It was an excellent comment the chair made before. We do not keep pushing them on physio if surgery is needed. What we do not have at the moment in Queensland is the spectrum of services which, as Simon commented, are well integrated and coordinated that people can go to and then get the right dose of care, depending on what is required. That is what we need to have in Queensland.

CHAIR: Thank you for that. The Mater presentation talked about a young adult health service. Is that a model that you think would be beneficial in the public health space?

Prof. Scott: That is an excellent model. In addition to what Simon and the team at the Mater do, which is so good, we can step up another level of our care for that higher complexity. At the moment, the Mater cannot manage those very serious presentations and they rely on the public mental health service. They do it very well in partnership with the others, but that is exactly the sort of model we need in our public mental health services.

CHAIR: With the scenario you just described, it sounds to me like quite a serious pathology that that young chap had. The sort of mild to moderate illnesses—and it is hard to group them all together but let us call them mild to moderate illnesses for now—would seem to be a completely different disease process. How do we break those two apart and make sure that the right people are getting the right treatment at the right time?

Prof. Scott: One of the big issues is access to care. At the moment, the whole system is constipated. We have people seeing clinicians for way too long. You cannot get into see mental health services. We need that flexibility in the system whereby general practitioners who should be coordinating this can say, 'Gee, you have a more serious illness. You need to get to a specialist mental health service.' If we have youth mental health services there with the expertise, we can say, 'Actually, you do not need this really high-level service. You can go down and have basic outpatient services provided by your private practice, psychologists and so forth.' Alternatively, if they do need a very specialist care, like the young person I just described, it is there for them. Right now, it is very ad hoc. People cannot get in to get that assessment to work out what it is they actually need.

CHAIR: Professor Tracey, you talked about local planning. The federal Productivity Commission also talks about the need for localised planning, and it proposes models with or without the involvement of a PHN. Is that what you are talking about there—trying to work in a particular town or region to make sure that public, private, non-profit, NGO and community services are well integrated?

Prof. Tracey: Beautifully described. If you think about some of the work that we have done through COVID, that is what we have done. You think about some of the work that we do—and I defer to my colleague Dr Stathis in relation to this—across oncology networks, cardiac networks. There are models for how we do this, and we are good at them in Queensland. If I think about the integration that you have described, we heard from our colleagues in Education talk earlier about the work they are doing. I believe that it is absolutely critical to have a localised response. It is important to deliver care in the right place at the right time that is safe care, as close to home as possible.

CHAIR: Who should drive that planning process? Is it a PHN? Is it the local HHS? Is it some other body?

Prof. Tracey: In a pure sense it will be co-designed, but in a policy sense I think it is really sensible that we have an overarching lens on that from a government department. They would work what I call in a commissioning model to provide the resources and the support for a localised response to these issues. In that way you are going to grow local capacity and capability, and local HHSs or local entities will spend that money where the need is. I think we need to rethink about how we transform that work and, again, already we are doing that in the broader health system. We think

about this for oncology networks, for cardiac networks and for nephrology networks. I believe we need to have mental health a little bit closer to that health reform so that we can take advantage of some of the policy thinking that is going on.

Dr ROWAN: Thank you very much for attending today. My question is to the Mater Young Adult Health Centre and to Dr Simon Denny, and congratulations to you and your colleague Greg McGahan for all of the work that you have done. I should declare that I am a fellow of the Royal Australasian College of Physicians Chapter of Addiction Medicine. Just coming to adolescent and young adult physicians and the notion of a registrar training program—importantly, you have outlined issues in relation to that development of the speciality and the lack thereof so far as the numbers are concerned and given that the Mater Young Adult Health Centre is a centre of excellence, for want of a better term around it—what would be the capacity of the Mater to facilitate in a piloted way, if there was funding allocated, to not only train some registrars within that particular speciality but also look at what could happen from a nursing or allied health perspective to then create further workforce capability—because the Mater is a public-private institution—and then signal that to the healthcare system overall as another way of translating that? Is it possible for the Mater to do it, what would that look like in terms of numbers of training positions and what sort of funding would that require?

Dr Denny: That is a great question. We have established the first training position for AYA registrars in Queensland, and that was the inaugural fellow last year. We also run training programs for GPs and other health professionals who work with young people, and we have also partnered with QCH to do the ECHO, which is an online clinician support community of practice model which has been really successful as well over the last 18 months.

One of my dreams would be to be able to do exactly that: have interdisciplinary training or transdisciplinary training, so we are not just training doctors but we are also training nurses, psychologists, social workers and allied health in young adult medicine care. That is how I was trained in Minnesota. Where the gap is at the moment is at the university level. The medical students, nursing students and social work students come out with absolutely no training in young adult mental health by and large. That is the real gap, so we need to start working at the university level—and that was some of the work I was doing in Auckland—and then the postgraduate level is where you can do that sort of program. Again, it would be ideally done in partnership with a university because then the training is recognised for those allied health and medical practitioners. Again, if you use that education model, it is not hugely expensive. You just need to bring together the expertise. Again, I would be arguing that these young people—these clinicians—who work with them are already there, but we just need to bring them together.

Dr ROWAN: Professor Scott, congratulations on the Early Psychosis Service at Metro North. How many of those sorts of services exist in Queensland at the moment? Given the comments around the spectrum of services—having that in that integrated and coordinated way that you talked about, and this comes back to the question that the member for Greenslopes, the chair, was asking earlier—where in the system is that strategy driven to try and create those extra services? Is that within the Mental Health Alcohol and Other Drugs Branch or does it rest with the Queensland Mental Health Commission? Where does it rest to try and look at the work that has been achieved to date through centres of excellence and then driving additional services to plug that gap, because you really need someone to have ownership and responsibility for that within the system to try and create those models and then do all the workforce planning and the infrastructure that is required and the communication within that? Where within the actual system does that rest?

Prof. Scott: Thanks, Doctor. There are a number of questions there. I could count four early psychosis services in Queensland run by Queensland Health and two run by headspace, so that is my understanding of that landscape. In terms of the governance of these, which I think is what you are talking about, and integrating, I think there does need to be some sort of shared overarching model between the PHNs and the HHSs so that they can kind of see how these different services can link together. At the moment they are sort of siloed and that lack of integration is a real problem—a real problem.

In terms of the strategy for developing these services, I can speak to what happened in Metro North. There was no budget for an early psychosis service, so the executive director took it upon themselves at the time, about 10 years ago, to say, 'These young people are getting lost amongst a sea of other people with chronic schizophrenia and so forth,' and he started dedicating some resources, so each year there has been a little bit more, but what he has done is taken services which are desperately needed for another population to create the service. There is no dedicated funding in Metro North for early psychosis services and to my knowledge there is none for young adults throughout the whole of Queensland from the HHSs. I think it is only where services take it upon themselves and say, 'We want to do something different for this population,' that it happens.

Mrs McMAHON: My first question is in relation to our capacity in beds in the youth mental health space. I know we got the submission from Queensland Health and it spoke about available beds across the state, but in terms of specific, dedicated youth mental health beds and capacity are you able to provide the committee on notice information about the capacity and where those beds are located throughout Queensland?

Prof. Tracey: There are two responses to that. One, I would defer to Dr Stathis for some of that detail and, yes, of course I would be very happy to provide that detail on notice to the committee.

CHAIR: If you could take that on notice, then.

Prof. Stathis: In terms of adolescent mental health beds, there are 66 beds across Queensland in a number of HHSs—and they are HHS specific, though they do flow. For instance, there are no dedicated adolescent beds in Central Queensland but they flow down to the Royal Brisbane and Women's Hospital. For child beds there is one unit—it is a statewide unit—at the Queensland Children's Hospital and they have nine beds, which includes a family unit so people can come from all over Queensland and stay at the hospital.

Mrs McMAHON: How are we in terms of capacity? We are hearing that in the clinical setting there are not enough beds. Whether you are in the private sector or the public sector, does Queensland need more child and adolescent capacity in terms of beds? Knowing that is the crisis and acute end and there is other stuff out in the community that clearly we need, how many and where do we need this capacity, noting that if we can at best deal with it at that younger age we are preventing more long-term issues?

Prof. Stathis: The answer is yes, we do need more beds, but also we need them at the right places, particularly in regional areas. I will give you an example, because families do not want their very unwell young person to be transferred hundreds, sometimes thousands, of kilometres away. I will use an example and I know the data. There are eight adolescent acute beds in Townsville and the flow is from Cairns and from Mackay, but anywhere between 80 per cent and 90 per cent of young people are admitted locally into the Cairns Hospital and Mackay Hospital. Although there are no dedicated adolescent beds and no dedicated funding for them, the reality is that that is where they get the best care close to home. It is not that they will not get care at Townsville, but parents—and I am a parent—understandably do not want their kids transferred.

The other important thing for many adolescents—and I am not discounting the distress and suicidality that they experience—is that many adolescents recover quite quickly, unless they have an evolving psychotic illness for instance. If they become acutely suicidal, it is not uncommon that they only need two or three days in hospital. You do not want to transfer your child far, far away to another hospital for a couple of days and come back.

Going to the other question you asked about the stresses, it is not uncommon to have significant stress on adolescent beds and for people to be waiting 24 or 48 hours. I know that last year there was a young person who waited in an emergency department for over three days for an acute bed.

Mrs McMAHON: I guess that was going to be my next question. My experience in the system is with transporting people under EAs to an emergency department—various different age groups—and it is pretty much a free-for-all in there. Do we have services and where do we have the services where QAS and QPS are bringing in young people because they have been called for whatever reason to transport and do assessments? What services do we have and are our A&Es equipped to deal with young people coming in presenting with mental health issues?

Prof. Stathis: Once again I can say that, based on last year's data—it was in the submission—about one in five presentations to the ED was for young people who were suicidal or self-harming. Where there is a significant gap is in trained personnel who are sitting in the EDs who are able to rapidly assess and manage young people. As you are aware based on the submission, there was a 29 per cent increase in acute referrals across the state, particularly for adolescent girls—a seven per cent increase over five years. I am aware of some HHSs that had a 100-plus increase. It is a huge strain on the system. These young people are coming into the ED, and the people who generally then have to go, particularly in regional areas, to assist these young people are the mental health clinicians who are working in the community CYMHS, so it is a double whammy. You are eroding the capacity of the community CYMHS to provide treatment because they need to go to the EDs to deal with acute assessments. That is a significant issue.

Ms CAMM: I thank you for raising that. I am from regional and Central Queensland and exactly what you express is correct, I can say, as a mother of three young adults with friends. This may be a question for you to take on notice for the Mater and also Queensland Children's. I am very interested
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to understand the data over the last two or three years on the referrals to your services that you have received from regional Queensland, given that you are a statewide service, whether public or private. For me, it goes to the heart of the question around accessibility in regional areas. I am happy, if required, for that to be taken on notice, if you have that data.

Prof. Tracey: Yes, we do have that data and I am very happy to provide that on notice; thank you.

Ms CAMM: Thank you. My second question is really around that acute period of suicidal time frames. Professor Scott, you outlined that story as an example. Sadly, in my community I fear that that young person would have either taken their life or would not have recovered because of the lack of access that you outlined—and you touched on it probably, Associate Professor Stathis. I am really keen to understand what is contributing to that, or do you know—is there evidence and statistics?—what is the contributing factor to young people now who are considering suicide? The data seems to demonstrate a rise over the last decade or even more recently, and you quoted statistics of young women in particular now. What are the major contributing factors to what we are seeing at that acute end of mental health and those suicidal tendencies? I ask that question because we have seen an increase in particular in my community of local young teenage girls who have taken their lives.

Prof. Scott: The extraordinary response to that question is that we do not know. We do not know, and I think it is the single most important question in mental health in Australia at the moment: why have we seen more than a 50 per cent increase in mental health problems in young women in particular over the last 12 years? This was all pre pandemic and we do not know why that is. We have just completed three surveys of the prevalence of mental disorders in adolescents in Vietnam, Kenya and Indonesia—low- and middle-income countries—and there is barely a problem there. It is barely a problem. When we asked them they said that they did not have enough money to put food on their table during the pandemic times of COVID but rates of depression, anxiety and suicidality are extraordinarily low. So why is it in our high-income country we are having such enormous problems with this and yet in other countries with far less resources it is much less of a problem? To me, this is something we are not putting in the effort to answer, but what I think is that there is this enormous societal problem and that is flowing down and the symptoms flow into the health sector but there is actually something upstream in society that is making it very hard for our young people to grow up healthy and resilient.

Prof. Stathis: As James said, the evidence is clear. The reality is that this generation of young people are sadder, more anxious and more despairing than any generation in the last hundred years. There are lots of theories but we do not know the reason, and that is tragic. I think, as James once again said, that is a central issue that we need to address, and it is not just health's issue; it is a whole-of-society issue. People often say that it is social media, and certainly social media influences society but it also responds to changes in society. So it is not just a simple answer and we need those answers to know what to do.

CHAIR: Greg, many of the young people in your service are obviously in an acute phase of an illness—a more advanced phase. Presumably, a lot of them would have been diagnosed by a GP or perhaps via a visit to an emergency department. In your opinion or based on your experience, is there more that can be done to help people who have been diagnosed to prevent them from progressing to needing acute care services in a hospital setting like yours?

Mr McGahan: I think certainly that integrated story of service delivery that we have heard of is very helpful. If someone does have a diagnosis or has been to an emergency department, it is making sure that you can wrap those services around them. Young people present with multiple complexities. It is very rare you would have a young person present to any mental health service purely around pressure or anxiety; there is usually a whole lot of other factors at play, whether that is their peer relationships, their education, their schooling, family issues. Having some capacity for your services to respond at the different layers that the young person is having difficulties at I think is really important, so those integrated models of care, good partnerships with other agencies and seamless ways to get young people to those other agencies. Certainly over my career I hear young people tell me the story that it is death by assessment: you go from place to place to place and you tell your story over and over and over but it is often very hard to get into treatment, and young people I think get a bit fatigued with that. I think they sort of get a bit wary of the system as well, so we need to have good integrated models and people who can respond at multiple layers.

Mr O'ROURKE: It is interesting when you look at some of the statistics around the increasing suicide of our young people, which is really concerning—and I know that we are working with Education and across various independent and private schools around trying to improve services to
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our young people. I know that you said we do not have the research there as to why it is increasing, but is there anything you could suggest that you think we should be implementing into our schools to actually help our younger students in the interim, until we really work out what is going on?

Prof. Stathis: The government has invested in the Ed-LinQ program and when I talk to colleagues across Queensland, particularly in regional areas, they speak of the value of the Ed-LinQ program. I am also well aware of the government's investment in psychologists and other clinicians across Queensland. Once again, it is improving those links to make sure that young people are managed rapidly and effectively at the time they need care. That is easy to say but very hard to roll out. Once again, if we have this fragmented, piecemeal system that we are currently working in it makes a hard job or a challenging job even more difficult.

Prof. Tracey: Might I also add that I am anxious for the committee to understand that collectively we are not sitting on our hands around these issues. We recognise them and they are challenging, but you will have heard from experts that we are actually trying to do something about this. Another good example is some of the work that we have done with general practitioners in schools. That was an initiative that we kicked off with Mabel Park high school, so Children's Health Queensland worked with Mabel Park high school to test having a general practitioner in the school to pilot that model. We worked with the Department of Education and the University of Queensland on that model. That model has now been funded by government and will be rolled out into over 50 schools across the state. There are green shoots for approaches that we are testing here in Queensland that work for the Queensland population, and I commend that model to you in particular to have a closer look.

Mr O'ROURKE: Yes. It has been implemented into one of our schools in Rockhampton.

Ms KING: Thank you all so much for being here and thank you for your great care for our young people across the course of your working lives. I want to ask a question or two about the increasing complexity of the young people who present for care. I have had examples in my electorate—in fact, even before I was elected for the first time—where I was being messaged with these astonishingly severe and complex scenarios of great suffering, and I want to just explore what barriers to care there might be. For example, if an eight-year-old presents with, among other things, family trauma, traumatic history and daily drug use of, say, ice, can they walk through one door and get the care they need or are there barriers to, say, participation in drug programs because they are eight? What would be the pathway for that imaginary person?

Prof. Stathis: I can answer that and then I will give you another common example as well.

Ms KING: Yes, please.

Prof. Stathis: So for the eight-year-old it would be difficult because there are very few drug and alcohol services for that young a population. Also in terms of continuing follow-up in the community after they may have been seen and supported in a child and youth mental health clinic, there are extremely limited options, and that is a huge gap—that primary school age gap. There are lots of missing middles. One of the missing middles is that five- to 12-year-old. We have had investment in the zero to fours. It has been very welcome, and you will hear some evidence this afternoon from Dr Elisabeth Hoehn. We have had support and investment in the adolescents. There are still many gaps, but that missing middle is significant.

Moving on from that, if I go around the state and ask my community CYMHS services what are some of the key challenges, without a doubt they will bring up those extremely complex young people with neurodevelopmental problems, usually ASD, who come to them with large NDIS packages, and when the NDIS rolled out disability services was cashed out. They come with their NDIS package, and I have spoken to families with an NDIS package of tens of thousands and sometimes \$100,000-plus. As you are aware, the NDIS does not cover medical, so there are these families who have no access to medical support. They have young people with significant behavioural and mental health problems that are going to be longstanding for many years. Although they have large packages, they cannot afford private psychiatry support—not that you can find one. The waiting list in Brisbane is 12 months currently for a private child and adolescent psychiatrist. They cannot afford private paediatric support so they come to our community CYMHS, but the model that we have for community CYMHS does not support these families. Community CYMHS provide a very good service but for a limited amount of time within a multidisciplinary team. These families are coming and saying, 'The NDIS is funding the multidisciplinary team. We don't need a psychologist or a social worker or a youth worker. We just want dedicated psychiatry time,' but that is not the model. They also want psychiatry time for 10 years. If they are eight years old, they want it for 10 years, which is once again not the model we have. It is a significant gap that is causing much distress across the community for the families. There are just no supports for these people.

Ms KING: So what we are hearing about there is system rigidity?

Prof. Stathis: Yes.

Prof. Scott: If I can just add to what Stephen is saying with the NDIS, what that has done is take funding away from services that did provide integrated care and give funding to families and consumers who then purchase in their care. But the care providers do not talk to each other, so the care that gets delivered is not coordinated, it is often ineffective and it does not make a difference. What I see very commonly in my clinical practice is people saying, 'I have a psychologist, an occupational therapist and a speech therapist coming in weekly to look after me.' I say, 'What do they do?' They say, 'I don't know what they do. I don't know, but I have to spend my money so I get them coming in,' whereas previously care would have been provided for people and it would have been coordinated. There would be some clinical governance—some clinical oversight—saying, 'This is what this person needs.' Now it is just these packages of care coming in so the funds get spent. That is not the case for everyone, but it is for a lot of people.

Ms KING: Is there a need for effectively a kind of My Health Record that also covers mental health therapeutic service delivery that records that so that that information can be accessed, with permission, by varying service providers?

Prof. Scott: I think there needs to be some sort of leverage by which if people are getting care from multiple sources they have to talk to each other. This should be one of the prerequisites. If you are providing disability care through the NDIS, you are getting taxpayer funded to provide that care. You need to talk to the other service providers to find out what you are each doing and what your role is. At the moment that does not happen.

CHAIR: That is potentially a whole other inquiry.

Dr ROWAN: I just wanted to come back to schools and, as has already been mentioned by a number of representatives here, the \$100 million Student Wellbeing Package. I want to ask around the model because, if I understood it correctly earlier from Dr Denny about avoiding that fragmentation and improving coordination and the co-location within schools as opposed to having visiting people into the schools, some of the experiences in New Zealand in terms of actually embedding and co-locating those types of facilities in schools can, as I understand it, achieve more optimal outcomes. Are there any particular recommendations you could give to the committee as to how that could be piloted or what that would look like given Queensland's experiences and also based on New Zealand?

Dr Denny: That is a great question. My comment was based on research that we did in New Zealand across 9,000 secondary school students, looking at the different models of care going into those schools. By far the best model was what we called team based care, and that was often led by a nurse who was there for the whole school week and that nurse was a generalist who was able to deal with physical complaints but also mental health to a large degree. In that team were often people like social workers, and GPs were a crucial part of that because they enabled the nurse to work as top of scope. What we found in those schools was that they had a 50 per cent reduction in suicide attempts compared to the visiting school model, and I can provide the committee with that paper if it is interested. So the model of care is really around team based care where you have multiple professions but they are working together as a team, and that is what those schools saw themselves as—as a team providing the care rather than individuals.

CHAIR: We will get you to provide that paper, if you do not mind. We will now conclude this segment. Thank you all very much for your contributions here today. I am sure every member of the committee could have asked you many more questions. We will send through some additional questions afterwards. To the folks from the Mater, I am personally very interested in your work around people with intellectual disabilities in the healthcare system. I think that is an area where there is a huge amount of need. There were several questions taken on notice. We would like a response, if possible, by 18 February. Thank you very much for your time this afternoon.

Proceedings suspended from 1.16 pm to 1.48 pm.

DAVIES-ROE, Ms Sarah, Coordinator, Perinatal and Infant Mental Health Early Years Project, Queensland Centre for Perinatal and Infant Mental Health

HOEHN, Dr Elisabeth, Medical Director, Queensland Centre for Perinatal and Infant Mental Health

SISKIND, Prof. Dan, Professor of Psychiatry (via videoconference)

CHAIR: I would like to invite each group to make a brief opening statement. If we could keep it brief that would be great as then we will have more time to ask you questions. Dr Hoehn or Ms Davies-Roe, who would like to lead off?

Dr Hoehn: I will. My colleague and I would like to begin by respectfully acknowledging the traditional custodians of the land on which this meeting is taking place, the Jagera and Turrbal people, as well as the traditional custodians of all land and sea countries across Queensland. We pay our respects to elders past, present and emerging. We also recognise the lived experience of mental health issues of the infants, young children, parents and families we work with and the contribution that this makes to the work that we do.

I am Dr Elizabeth Hoehn, medical director of the Queensland Centre for Perinatal and Infant Mental Health. My colleague, Sarah Davies-Roe, and I thank the committee for the opportunity to provide the following opening statement. The Queensland Centre for Perinatal and Infant Mental Health, or QCPIMH, was established in 2008 by the Department of Health's Mental Health Alcohol and Other Drugs Branch to be a statewide hub of expertise for the development of a continuum of care in perinatal and infant mental health for Queensland. QCPIMH is now hosted by Children's Health Queensland Hospital and Health Service. We work in partnership with other government departments, private agencies, tertiary institutions, non-government organisations and consumers and carers to develop a continuum of care in perinatal and infant mental health across Queensland. This continuum of care includes inpatient and ambulatory community based services across all sectors of care.

Since the centre has been established, a range of achievements have been made. We support the HHSs to establish community based perinatal and infant mental health positions as well as supporting the four-bed inpatient unit at the Gold Coast. Together in Mind is a collaborative perinatal and infant mental health day program that is delivered by mental health and child health clinicians. This has been developed and implemented across 13 HHSs. ePIMH has been established as a telepsychiatry service delivered to regional, rural and remote sites in Queensland. Birdie's Tree is a suite of resources to help young children prepare for, cope with and recover from a natural disaster or disruptive event. It builds resilience and has become a vehicle to support the work of the early childhood education and care and community sectors.

We also have created a suite of Aboriginal and Torres Strait Islander perinatal and infant mental health resources that have been co-designed in collaboration with communities across Queensland. COVID-19 Unmasked is a national and international research study to find out how young children aged one to five and their families in Australia are coping with the COVID-19 pandemic. We collaborate with and support services such as the peer-led Peach Tree Perinatal Wellness service, the Mater Hospital's build for mother-baby beds and the Stride mental health early social and emotional wellbeing service in West Moreton. Partnerships are the key to how we work, and currently we have a significant partnership, which my colleague Sarah is leading and is being done in partnership with the Queensland Mental Health Commission to look at early years and pathways of care.

As you have already heard, mental health service delivery is a complex system with many challenges. You have heard about the constant tension between needing to put more ambulances at the bottom of the cliff versus building strong fences at the top—even more so at times of crisis, such as the pandemic or natural disasters. The reality is that a strong and effective continuum of care in perinatal and infant mental health needs both to provide good care and to bring about change and make a lasting difference. The challenge is how to create a balance in investment.

What do we need to achieve that continuum of care? Firstly, we need the research and the evidence that points us in the direction of what we need and we now have that in abundance from many cross-disciplinary sources and elegantly collated on the Harvard Center on the Developing Child website. So we know what we should and need to do. We need a reason to do it. From an individual and a clinical perspective, investment into prevention and early intervention can affect the future trajectory of a child and help reduce the impact of intergenerational trauma. It makes a difference in the lives of individual children in Queensland and their families.

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From a financial perspective, investing in prevention and early intervention will be the backbone of minimising the economic and societal impact of mental illness in Queensland, not only for this generation but for generations to come. From 2019 research by Teager et al we can estimate, using quarterly population estimates from the ABS for zero to four-year-olds, that the cost of late treatment for Queensland would equate to over \$600 million per year. James Heckman, a Nobel Prize-winning economist, has shown that high-quality birth-to-five programs, particularly those that we commence early in pregnancy, can deliver up to a 13 per cent per year return on investment in outcomes for education, health and social behaviours. We have significant reasons to drive what we should and need to do.

We also need policies and plans, and you have heard about some of those. They are emerging now for this area of practice and the evidence has become compelling to proceed with that. The World Health Organization, the Commonwealth government—there are many policies, reports, frameworks, guidelines and plans, including for mental health, child safety, domestic violence, early childhood education and care—the Productivity Commission and the recently released national children's mental health and wellbeing strategy, all of which are relevant to perinatal and infant mental health across numerous agencies. The Queensland government similarly has many policies and plans across agencies, but particularly relevant are the mental health plans from the branch and the commission, as well as the cross-agency informed Queensland Children's Wellbeing Framework and 'A great start for all Queensland children' early years plan. We are on the way from policy and planning to guide what we should and need to do.

However, then we have to implement. Queensland already has a foundation to build on in the perinatal and infant mental health space with examples of amazing work, many of which are driven by the passion of those who established and developed them from a patchwork of funding across many sectors, but this is only a beginning. We continue to have high levels of need for perinatal and infant mental health services across Queensland from preconception until school entry, with some areas at disproportionately higher risk.

You have also heard about fragmentation, silos and poor integration. We lack a systematic and sustained approach to service implementation and integration close to the places and communities where families live in order to create the continuum of care across sectors that we need. You have no doubt heard the saying 'it takes a whole village to raise a child.' Our challenge is to create that village for Queensland in an integrated, holistic and sustainable way, at an agency and system level, at a service level and at the place based community village level across a vast and varied state. We all have a role to play. Relationships with families and each other are the key. We have to create opportunities and investments to work, plan and develop a service system together. Thank you.

CHAIR: Professor Siskind, did you want to make a brief opening statement?

Prof. Siskind: I am a psychiatrist at the PA Hospital, but I am here as an academic psychiatrist from the University of Queensland. I would also like to acknowledge the traditional custodians of the land. I am in isolation with my family this week so I am on Jagera land. I would also like to honour the people with lived experience of mental illness and their carers.

I have given you a nice dry report, but I will try to keep you a bit more entertained with what I am telling you today. Unlike the people who spoke, I am at the complete other end of the lifespan. I work with people who have treatment refractory schizophrenia. To remind you, as I am sure you have read in the reports, schizophrenia impacts about one per cent of Queenslanders. It normally starts mid-teens to sort of mid-twenties. It is an illness that is characterised by functional deficits: the ability to do things like pay your rent, keep your house, keep a job. These people have symptoms like auditory hallucinations and persecutory delusions where they believe people are out to get them. They have got high rates of physical health comorbidity. And it is expensive. In 2014 it was estimated around \$3.9 billion was incurred by government in providing care for people and about \$6.2 billion for the NGO sector—again that ends up being covered by government as well. When you think about physical health comorbidity, that adds up to an extra \$15 billion. Today in my opening statement I am going to tell you two things: first of all, we need to be thinking about the treatment of refractory schizophrenia, because that is core business, and physical health comorbidity, which is what I am going to try to point you in the direction of.

Schizophrenia: think about all that Queensland Health delivers and the services that you guys help to support Queensland to deliver. We are in the schizophrenia business. Seventy per cent of patients who are case managed by Queensland Health have schizophrenia. We have around 15,000 people in case management in Queensland. That is an awfully large number of people and you guys are supporting us to provide care for them, and we thank you for that.

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I will talk firstly around schizophrenia and managing it. I work for a service that does what we call intensive psychosocial rehabilitation. In layman's terms, it is about trying to provide people with the skills they need to not need the public sector anymore; to help people get out of the public sector and to move on. We are a little bit different from the NDIS. One of the things that you guys will be wrangling with is what is our business and what is NDIS business. In our business we have a multidisciplinary team where you have doctors like me, but more importantly we have nurses—and Joe, I know a lot of the nurses on my team love you and they talk to me about you; they were pretty excited I was presenting to you—and we have social workers and occupational therapists who work with a team approach. Our team, which is called a mobile intensive rehabilitation team, is a bit different to regular case management. Regular case management is working with 30 to 35 people; we have a one-to-12 ratio, which means we can do intensive work to give people individual self-management skills so they can look after their illness and leave the public sector to go to the NDIS and GPs.

I think about Ms R. She was referred to my team when she was about 19 and she was so functionally disorganised that she could not get a Centrelink payment. She did not leave the house. When I talked to her, it was only in single-word sentences. She did not leave her room because of her psychosis and anxiety. But thanks to the psychosocial work we have done, she is now in a relationship, she is living independently, she is studying counselling at TAFE and when I saw her at the last appointment, she said, 'Look, Dan, I don't really need you in my life anymore. I'm good.' That is one of the ways that we can provide people with intensive service and those are the sort of services James Scott would have told you about before lunch, to get people out of the service. We do great things.

The good news is if you live in Ashmore, if you live in Coorparoo, if you live in Beenleigh or if you live around the corner from Christian in Chapel Hill, you are going to get these services. But if you live in Eimeo, if you live in Mount Isa, if you live in Caboolture or if you live in Gracemere, you do not get these services. I will be calling for a statewide rollout of mobile intensive rehabilitation teams. We provide these coordinated skills of therapy so that people can graduate and then the NDIS, which tends to provide low-skilled workers and support workers, can take over. But we need to put the investment in Queensland Health to get people out of Queensland Health.

The second point I will make to you is around physical health co-morbidity. The consumers that I serve and the consumers you guys support die, on average, 20 years younger than the general population. The majority of deaths are from cardiometabolic disease—they die from diabetes and heart disease—and these are avoidable. Because of the nature of the illness, they have a sedentary lifestyle. I do not know about you guys, but I did not see my personal trainer this morning. I am in isolation, which is a great excuse not to exercise and I will find any old excuse. But people with schizophrenia will find even more excuses not to engage or they will choose the rissoles versus the salad and they find it harder to quit smoking. Their genetic profile makes them more likely to have cardiometabolic disease, and the medications that I am prescribing increase obesity.

I think about Mr B. He was a very bright bloke, went to Bond on a scholarship, did IT and developed schizophrenia when he was 25. By the time I met him about 10 to 15 years later he was living in a really substandard hostel. Luckily he got started on a good medication—clozapine. He got hooked in with my team, the MIR team, and got some psychosocial support from HASP, which became part of the NDIS services in Queensland, but he started gaining a lot of weight. Luckily we have an integrated endocrinologist in our service and we managed to treat his diabetes. His function has improved. He now plays social hockey. I saw him yesterday. Joe, you will be pleased: you know that nice little bike path that runs through Stones Corner?

CHAIR: I am glad you mentioned it.

Prof. Siskind: Good. Thank you very much for supporting that. He and his support worker from NDIS went for a bike ride along that path and he was telling me how great it was. Because we have the integrated physical health services to look after him, he is now using his body, rather than not using it.

We need to think about how we manage this brutal physical health comorbidity that the consumers we serve are faced with. Those integrations are about the greater integration of physical health and mental health. We have a gym in our clinic at Stones Corner, but it has been closed for two years because of COVID. We need to get exercise physiologists on staff in Queensland Health and dietitians to provide those integrated services. We need to have on-site physical health. We have an endocrinologist in our building whom we fund through option A. You guys love option A because it bills Medicare for services—it is great—but most other services do not have that. Cairns has a pilot service of that which has been really working. It is really hard for consumers with mental illness to go
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to hospital. They hate the hospital because it reminds them of traumatic hospitalisations. If you bring the services to them, then their do-not-attend rates go down and we get an efficient use of services. Then we need to get more integration with NDIS around looking after people to get them to dietitians and exercise physiologists.

That is all I wanted to say. It is basically about psychosocial services through Queensland Health to get people out of the services and pay greater attention to physical health comorbidity.

CHAIR: Thanks very much, Dan. I was really pleased to see your submission and a number of other submissions talking about the need to focus on both physical and mental health. It has been my experience in the past that often the physical health side of things for people presenting in a mental health context are not necessarily that well managed, and also can I say that vice versa is the case. You talk about people dying earlier due to what we might consider to be relatively preventable physical conditions, but is it also fair to say that for people who do not engage in good lifestyle practices like decent diet and exercise and refraining from things like smoking, those things will actually contribute to and exacerbate mental health conditions?

Prof. Siskind: Yes, that is a really important question about this kind of bidirectional link. I am thinking a little bit about schizophrenia and serious mental illness, which is the Queensland Health remit. Common mental disorders like depression and anxiety tend to be Commonwealth funded. Definitely we know that depression and exercise are intimately interrelated. In fact, the best possible treatment for depression is exercise and moving your body. There is definitely a bidirectional relationship there. People with diabetes are more likely to get depressed, absolutely. Trying to bring these together through increasing accessibility to physical activity in Queensland, such as bikeways or the community parks and gyms and community exercise programs, is really key to being able to assist with that.

CHAIR: I have a question for Ms Davies-Roe and Dr Hoehn. In terms of your service, what is the pathway that people take to be referred to your service? Is it via GPs? Is it via other community clinics like the child health nurses network? Also, do you do screening of all new mothers to try to identify people who might benefit from your services?

Dr Hoehn: All of the referral pathways for the clinical work that happens are not directly delivered by the centre, but referrals come really from across the sector wherever women with small children might make contact with organisations. That could be severe mental health services such as Dan has talked about, because a small percentage of them will present with quite significant mental health issues. Just because you have a mental health issue does not mean you are not a parent. They could come from a general practitioner, from a child health nurse, from maternity services, from the private sector, from community organisations that might interact with young people, from Aboriginal medical services—really across the board wherever young families present. In Queensland, we have universal psychosocial screening within public maternity services. That happens during the pregnancy if women present for booked appointments, if they develop symptoms further along down the track and in some cases, if there is good follow-up, you would have a postnatal check at six weeks as well.

After that, in Queensland screening happens in the context of visits to general practice, child health nurse presentations, increasingly through things such as iCOPE or the COPE platform, which is a nationally supported platform, women can self-screen and identify and present. The goal is to enhance the screening, particularly in the postnatal space. The Productivity Commission has really highlighted that that is an important follow-on. Queensland has invested in antenatal psychosocial screening within public systems, but we need to really broaden that out quite significantly.

Ms CAMM: My question is around in particular the perinatal presentation of women. Is there a particular cohort or trend that you have seen present? The second question: is there also a cohort where there are barriers, whether that be CALD women or whether that be First Nations women? Who is most prevalent to present and who is embarking upon that treatment pathway? Do you see also that there are barriers for other cohorts of Queensland women?

Ms Davies-Roe: In terms of presentations, what we know, from mental health right across the board, is that mental health affects all walks of life. When we are talking about perinatal we are thinking of conception through to the first year post birth. We are thinking about that perinatal period. Certainly we know that one in five women will experience either anxiety and/or depression in that perinatal period. Thinking about dads within the family system, we also know that one in 10 dads will experience either anxiety or depression in that perinatal period. Those presentations are on a continuum, of course, so there are some milder presentations through to more moderate to severe presentations. There is also a cohort of women who experience puerperal psychosis, which is at more

the severe end—that is two per 1,000 births. In terms of those rates from a perinatal presentation point of view, we know that there is a range of vulnerabilities that increase your risk. You identified the CALD women experience. We know that there are layers of vulnerability. Dr Hoehn spoke about the psychosocial screening. We also know that there is a range of factors that add to those layers on top of cultural factors such as CALD or Aboriginal and Torres Strait Islander women, but we also know that where there are concerns around homelessness, domestic and family violence, social issues, access to employment—that also adds to that vulnerability layer.

Dr Hoehn: If the mum or parents or caregivers have parental mental health issues, drug and alcohol abuse, justice issues—all of those adversities that present really increase. If there has been a history of childhood sexual abuse or other levels of abuse for the women and their partners, that is also a contributing factor. There are significant risk factors that will then heighten the chance in that period, which is actually an incredibly vulnerable developmental phase for women, partners and families. That leads to the presentations.

Dr ROWAN: I have a couple of questions for Professor Siskind. You were talking about complex schizophrenia or treatment-resistant schizophrenia or people with severe mental illness who are being managed by the Queensland health system. With respect to additional programs or services that are needed to manage that physical comorbidity, I want to ask about the models of care that could be put into place. Often if you have someone with treatment-resistant schizophrenia who is being well managed by a Queensland mental health service and they also have to have their physical comorbidity managed, they might have a GP but are then referred. If they have diabetes, they go to an endocrine clinic; if they have a respiratory problem, they are off to the respiratory clinic; if there is cardiac disease, then they are off to there. I want to tease out and understand: with general physicians, the exercise physiologists and the others you talked about, in relation to managing physical comorbidity is there benefit in having a role for those types of clinicians and workforce imbedded within a model of care in mental health services to manage that end of the spectrum? If there is, what does that look like, where can it be piloted and how much would it cost?

Prof. Siskind: Christian, it is great to see you again. To warn the panel, I went to medical school with Christian so I have met this [REDACTED] before. You have to put up with him more now than I do.

CHAIR: I am just pulling you up on that unparliamentary language there! Wipe that from *Hansard*!

Prof. Siskind: Hopefully that is taken out of *Hansard*. I think Christian's question goes to the nub of this. I do not know if you guys have ever been crook, but I have had a chronic illness and I had to negotiate trying to get to hospital, trying to get a bunch of tests and trying to see my specialist. I have a PhD and it is damned hard to do. If you have an illness that presents with cognitive deficits and you are struggling to pay your rent, then navigating the healthcare system is nigh impossible.

Christian's question goes to what a model of care would look like. In fact, Queensland Health has piloted some of these models of care by employing nurse navigators. There are a couple of models in play at the moment around nurse navigation. If you are a GP and you have someone with a mental illness who is not part of the mental health system but is having trouble accessing Queensland Health services, the nurse navigator will outreach to the consumer to help them get to their appointments, work out what the recommendations are and explain those in plain language. The second is nurse navigators who are inwardly facing for people who are open to the mental health service. I struggle to work out when my patients have appointments with their endocrinologist or with their surgeon or other services, and I am pretty good at using the healthcare system. Those people are basically trying to pull together all of the information and are making sure that people turn up on time to their appointments, because Queensland Health loses money when someone does not turn up to a doctor's appointment. Missed appointments equals missed revenue, especially if you are doing an option A clinic.

Christian, I would argue that it is very cost-effective to provide nurse navigation for consumers with mental illness around their physical health comorbidity. These models have been piloted in some of the larger services and I think they are worthy of rolling out in some of the other services. I think also—again I am an academic, so I would say this—if you are going to run a service, you need to evaluate it and find out if it is cost-effective. One of the challenges we have in our state healthcare system is that we will put the money into the services but often the money for evaluation never happens. I really think it is important that if you are going to trial a new service then you should evaluate it and find out if it works. We have seen these systems work, but they need evaluation.

Dr ROWAN: This question is for the Queensland Centre for Perinatal and Infant Mental Health. I want to get an understanding of the data that is captured to drive translational improvements in perinatal and infant mental health across Queensland. I guess it is about closing the feedback loop of that information that is captured there and liaising with hospital and health services, primary health networks or others. Is that occurring? Are there any recommendations you could give to the committee as to how that could be best done to ensure that information that is being captured can drive improvements when it comes to the psychosocial determinants of health and other things that are being done by various organisations and other elements of government, not just within Health but across the board?

Dr Hoehn: There is some data gathered. At the statewide service support level, the centre itself does not actually deliver a lot of services directly. For those that we do, we do collect data from them and that is fed back to the Queensland mental health branch. Through the electronic record systems that our clinicians within the health system use around the state we have supported making modifications that allow us to try to collect data on the families that are seen. The coding system that we use in ICD-10 does not have a lot of information that can pull out perinatal mental health diagnoses, so we have tried to find other ways of gathering that information. Through the work that we do in supporting other services, we try to support them with their evaluation. We try to build that in. As Dan said, it is essentially to build that in from the beginning.

Data is collected from the perinatal screening that is done in maternity services and that gets added to the perinatal dataset, which then gets fed into the AIHW dataset. There is work being done at a Commonwealth level at the moment looking at how we can more effectively gather that data. That project is just starting at the moment. They have just had ethics clearance to progress that and they will be working with every jurisdiction to look at exactly what data we should collect from screening. At the moment there is really only very basic data collected. We are very much at the beginning in perinatal and infant mental health.

The complexity is that because state funded services are at that severe pointy end of the spectrum, as Dan has been saying in terms of severe mental illness, it is only a very small part of the population that presents with perinatal and infant mental health issues. For a significant amount of that sector the service delivery happens right across the sector—private, public, non-government organisations and Aboriginal medical services. It is really difficult to look at how we can actually collect consistent, strategic data that will provide information. We are kind of on the cusp at the moment of looking at screening tools that are consistent and that can be used in every sector. That rollout is going to take quite a number of years to achieve.

Mr O'ROURKE: Professor Siskind, in your submission you talk about the Housing First model. Could you expand on how that actually works and what are its benefits?

Prof. Siskind: Thank you very much for asking about housing support, because this is a really huge issue for people who live with mental illness. We know that housing affordability is a problem in Queensland including in some of our regions. Most of the consumers that I serve are on the pension line. They really do not have a lot of disposable income, so there is a real need for department of housing stock for them.

In Queensland, which actually has a very functional department of housing, the Housing First model becomes less essential. In areas where there really is a dire need for housing and poor community mental health services—less so for Queensland, but places like the US, where I trained—Housing First basically says to people who are untreated for their mental illness, 'We'll give you a house and once you are stable we will bring the treatment,' whereas other models say, 'If you don't have treatment you don't get a house.' In the Housing First model the house is the stability, the building block, to allow people to have somewhere to live and not be homeless so that then they can engage in treatment.

One of the nice things in Queensland is that we are actually not too bad at the sorts of services we provide through Queensland Health and the department of housing, as well as through our community housing service providers that provide the integration of support that we have in Townsville, Logan and central Brisbane—homeless support teams. They are called HHOT teams. They provide outreach to people who are sleeping rough and then help bring them towards department of housing or community housing units through the NGO sector and mental health services through the public sector. The Housing First model is a really good model when you have really intractable homelessness problems to help provide people with somewhere to sleep and somewhere to live so you can then bring the support services in to them.

Mr O'ROURKE: In your submission you mentioned the Step Up Step Down model? Can you explain that?

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Prof. Siskind: I am glad people read my report; I am touched. One of the challenges we face in Queensland is that usually there are not enough mental health beds for all the people who are acutely unwell. We have a large prevalence of illness, as we do in most parts of the world. The Step Up Step Down model is about providing services that are not just psychiatric hospital bed based.

Let's say you have had some increase in suicidal ideation and you are in the community. You need somewhere to be safe, away from other people who might be using or are a bad influence. The model provides residential support services that are not quite as intensive as a hospital to give people that area of safety and space. There is a nice one that runs down in Logan called Acmena House, which is a lovely model of this. Then for stepping down, just say you have someone who has had an acute hospitalisation. They may need a little bit more time to get their medication sorted out or maybe they are not quite ready to go home independently where they have to clean the fridge, deal with the mess in their place, organise their shopping and organise their cooking. It gives them a few extra days to get a bit more stable before they go there. Stepping up is from within the community, providing a slightly more supportive place; stepping down is from the inpatient psychiatric hospital. We did some evaluations of these services in Queensland: they save you money and they keep people out of hospital, so they are very cost effective.

Mr O'ROURKE: I am thinking about regional Queensland. If there were more Step Up Step Down models in the larger centres, that would have to be beneficial for our regional consumers. What are your thoughts?

Prof. Siskind: These sorts of things need to be in regional centres as well. If you think about the homeless support services or these Step Up Step Down services, they are only available within five kilometres of Brisbane. In Rockhampton where there are increased housing costs or in Mackay where there are very high housing costs there probably is a need to provide these sorts of services to help people out of hospital and maintain their community tenure. We certainly need to increase their availability in the large urban centres, but for most of regional Queensland—and I worked in Cairns for the first few years of my career. Cairns, Townsville, Rocky and Mackay are certainly large enough centres to need these kinds of services as well. I do not know that this is just a city thing. I think the Step Up Step Down services can really benefit people.

There is a program in Cairns called First Service, which runs a Step Up Step Down program. They have had really good results in keeping people out of hospital. I suspect that folks in Rocky probably do not want to go to hospital. If you can provide them with a home-like environment where they can get those sorts of services it is going to keep them connected to their community, and that is a good thing.

Mrs McMAHON: While we are on the subject of housing, in my electorate we have some great department of housing new stock opening up all the time, which is fantastic because it is much needed. I also know from a policing perspective they are our biggest calls for service. A lot of that will have to do with the occupant's specific issues around mental illness, poor social skills and conflict that occurs. Notwithstanding things like Step Up Step Down and Housing First, through housing and the provision of public housing, noting the conflict that it often causes amongst our other vulnerable populations, how do we get the balance right in terms of providing them with the dignity of quality housing in locations where we do have services? In my area of Beenleigh there are a lot of services, so it is a good place to have department of housing and community housing. How do we best prepare these vulnerable people to be good tenants and good neighbours, particularly when there is a mix of vulnerable people, whether they be elderly, single mums, victims of DV? How do we get that balance right in our public housing?

Prof. Siskind: That is one of the most knotty questions you could ask me today. I want to unpack a few parts of that question. We have talked a bit about the residential mix in public housing. You have also raised some issues around being a good neighbour or appropriate sort of behaviour and then we have talked a bit about mental health. We have these department of housing units for people who have just left prison, people with severe mental illness, people who are raising families—and they are all kind of thrown in together. First of all, I want to dispel the myth that it is the mental illness that is causing people problems. I think a lot of it can be comorbid substance abuse, which certainly can be a problem for people who live with mental illness, but it can also be a problem for people who do not live with mental illness. When we think about unsociable behaviour, it is not always mental illness.

If we focus on the consumers who have mental illness, one of the things we do in my team or with these intensive psychosocial support teams is help people with their community tenure. How do you live appropriately? If you have auditory hallucinations that are causing you to shout out at night, we can give you some illness management skills so that you are not screaming murder at two in the Brisbane

morning and disturbing the woman next door who has two young children and is trying to do her best in raising them. Providing those intensive psychosocial support services we were talking about earlier is one of the key ways to help people maintain community tenure and to be a good neighbour.

The next part is going to be around providing drug and alcohol support services. If I think about my consumers, when they are having real trouble staying in the community it is because they have used ice or because there is other drug use going on. We did not touch on this in the report, but substance abuse, particularly around ice use, is a major problem. Providing integrated substance abuse services within mental health so we can deal with these two things together is really key to helping people.

Finally, it is about housing mix. Unsurprisingly, if you have a lot of people who have a lot of psychosocial problems and you put them in a tower block, you are going to have a tower block full of problems. This comes down to the department of housing providing an appropriate housing mix that has a blend of people who can get along well together. I think most of you have travelled to Sydney and Melbourne where in Fitzroy there are these tower blocks. Luckily we do not do this here in Queensland, but we do need to be thinking more creatively about how do we put housing units into mixed environments so that people can live together better. If you just put all sorts of people who are socially marginalised in the one block, you are going to have major problems.

CHAIR: I have a question specifically around schizophrenia, which you have talked about in your opening statement. You said that one per cent of the population will develop schizophrenia, yet they account for 70 per cent of the case management by Queensland Health. I am not particularly familiar with this disease process. Is it fair to say that for a person who is diagnosed with schizophrenia no amount of early intervention is going to prevent them from ending up in an acute mental health service and that at some point they are going to need hospitalisation and intensive treatment?

Prof. Siskind: I think James Scott, who is a close colleague of mine, probably would have spoken to you about that before. What we can say is that we do not know what causes schizophrenia and we cannot prevent people getting schizophrenia. We are doing some great research to try to understand that better. I work alongside the Early Psychosis Service. I share an office with the early psychosis team. They are pretty good at keeping people out of hospital and providing people with those self-management services.

Joe, what I think your question comes to the heart of is that schizophrenia is a really impactful illness in terms of people's life function. Queensland Health provides services to people who are really struggling the most. The feds do not do that. That is not the feds' remit. They leave it to the states. We can argue that a different day.

The sorts of things we deal with is we are looking at people who are presenting to the emergency department in suicidal crisis and then we are looking at people who have pervasive illnesses like schizophrenia who require ongoing support. Joe, one of the problems we have with schizophrenia is that it is a lifelong illness. People are going to have relapses and remitting episodes throughout their lives. You can provide some intensive early psychosis services from James, but it is possible that five years later people might have another episode or they might choose to stop treatment and they will get unwell again.

The main reason that we are doing 70 per cent of our case management for it is that it is a highly prevalent illness and it is a lifelong illness that requires intensive support. We might be able to get someone to leave their mental health service and keep them out of the mental health service for a decade. I was a registrar up in Cairns when I first started 20-odd years ago. I had a particular gentleman who, because of his belief structure, had ended someone's life. Now I am seeing him again 20 years later and this guy is an upstanding member of the community. He is really doing well. He has been on treatment. He does not require the mental health service anymore. He is closed to his GP. Just because people have had illness episodes does not mean they are going to have it forever, but there are going to be people who are unwell who are going to be having episodes throughout their life. I think we can help people get better and we can help them leave the service. It is just a highly prevalent illness.

CHAIR: I have a similar line of questioning in relation to perinatal services. I will start with foetal alcohol syndrome. Is that something that your service is engaged in attempting to prevent and identify people who might need treatment and early intervention or does that sit somewhere else?

Dr Hoehn: We would provide support to services that work with families, including our own service. Part of the centre has an infant mental health team that provides services. That team would work directly with families that present. Again, it is a very complex problem that is embedded in a significant broader psychosocial presentation. There are complexities with vulnerable populations

and other risk factors, but it is certainly something that really requires intervention early in the piece and very early in the piece in pregnancy and pre-pregnancy. It is a whole-of-community education. I think that is one of the difficulties in thinking about how we take this area of practice forward.

In terms of Queensland Health providing funding for this area of practice, it is just over 10 years now. Prior to that it was very much caught up or lost in other areas. We are very much working to get an understanding and advocate for the fact that there are some disorders that we can prevent, that we can impact quite significantly and that we can make a difference to the trajectory of. As Dan said, you cannot do that with schizophrenia because we do not know what causes that, but we can reduce depression. We can reduce the impacts of anxiety. We can reduce the emergence of foetal alcohol syndrome. We can work to try to reduce early childhood adversity. Wherever we can do that, it will lead to better outcomes no matter how severe the mental illness is. If we can help the development of better personality structures from the beginning, better resilience and better support systems, that will lead to better outcomes even for the severe end of the spectrum that Dan works with. It is a challenging place to work because it is not something that is just state funded. It is how we actually integrate and bring it all together.

The evidence is there now that we have to do that. The impact is not just on mental health issues. It is actually on physical health issues very broadly. That interface that Dan was talking about—physical and mental health—is there for every single one of us. The greater the adversity we experience very early in life the greater our risk of developing future mental health issues, depression, suicide attempts but also physical illness. The brain and the body are tied together through the HPA axis and our stress systems. We have to work very hard to minimise the impact of stress chronically and severely on our bodies because that will actually reduce the incidence of chronic obstructive pulmonary disease, heart disease, cancers and other conditions that drain our physical health system as well.

There is enormous evidence now for the importance of intervening early and putting that investment in. It is a real challenge. Dan is talking about the severe end of the spectrum and the enormous investment that is required at that end for people with very significant illnesses as adults. I am talking to you about the fact that we actually have to start right back at the beginning, before a baby is even conceived in the case of foetal alcohol syndrome, to actually make a difference to a system that is a generation away that we want to change. It is hard to get our head around. It is hard to prioritise investment. We feel very passionately that we are at a point where we have to start seriously thinking about doing that because our society cannot sustain the costs we have from substance abuse, from crime, from a whole range of other social problems that are emerging really significantly that we can help much earlier if we invest there.

CHAIR: I want to ask a question in a practical sense around foetal alcohol syndrome. At what point do you need to have a mother stop consuming alcohol for it to be effective in terms of preventing FASD?

Dr Hoehn: Ideally before she becomes pregnant. If not, as soon as possible when she becomes pregnant.

CHAIR: Really it is at that point of population health rather than screening and trying to target individuals.

Dr Hoehn: Yes. That is the thing with this practice. It is multilayered. We have to advocate in a public health space. We have to develop resources to get that message out there across a diverse range of communities, as the member for Whitsunday has already raised. We are talking about populations that are culturally and linguistically diverse, that come from very different cultural practices. We have to educate and work with them as well as treat at the other end of the spectrum. The centre works across all of those different areas to try to start to make a difference.

Dr ROWAN: I want to come back to Professor Siskind. One of the key points you made initially in your opening remarks was that the committee consider the statewide rollout of mobile intensive support services or mobile intensive rehabilitation teams, which are outlined on page 3 of your submission, Dan. It was articulated well—the evidence base and the cost-effective nature of why they would be recommended. You may have to take this on notice. How many would be needed in Queensland? How much would that cost? Importantly, when we are talking about a statewide rollout of those and the benefits they could provide into the community and not just to patients, their families and the system, who would lead that? Would that be the Mental Health Alcohol and Other Drugs Branch? How would it be implemented in our governance model where there are individual hospital and health services? There is a centralised bureaucracy. Who would lead that strategy and work in collaboration with multiple stakeholders to make that a reality?

Prof. Siskind: The people who deliver this are the HHSs and the HHSs respond to the encouragement of the alcohol and other drug services. There is not necessarily a standardised prescription of what needs to be in every mental health service. There is a mobile intensive rehabilitation team. That is what they are currently called. They were mobile intensive support teams. We do tend to change our names a bit. These teams operate on the Gold Coast, in Logan, in the PA catchment, in the Royal catchment and in Cairns. There are certainly gaps along the coast. I think there is probably a need for them on the Sunshine Coast and in Caboolture as well as Rocky, Mackay and Townsville.

Where does that encouragement come from? It comes from the alcohol and other drugs branch but the funding has to come from the HHS. We need to make sure we are adequately funding mental health services in Queensland. Once the Victorian royal commission of inquiry had been done we realised that we had really run down mental health services compared to physical health services. One of the hopes is that when you have put your lens of attention on to this we will realise that people with mental illness and their illnesses do not have the same sorts of resources that we are providing for other physical health illnesses in Queensland and that the funding for mental health services has not matched. There does need to be funding to support these sorts of services.

Christian, you asked about cost-effectiveness. We have done evaluations of these teams internationally and in Queensland. They save the hospital money because they keep people out of the hospital. The intensive services help people avert additional psychiatric hospitalisations. As the member for Macalister asked around unsocial housing or situations where the police are being called in, if you are providing these sorts of services to help people maintain community tenure then you are not having police resources being diverted to a 2 am call-out to someone who is shouting out in an apartment or causing problems. The flow-on effects are not necessarily just to the health department but also to other services.

We show that we are very good at (1) keeping people out of hospital and (2) keeping people out of the mental health service altogether. The intensive burst of resources that we provide to consumers gets them to be closed to their primary care doctor and to the NDIS packages, which is again shifting the cost from Queensland Health to other healthcare providers in Australia. Although there is an investment that is required, that investment ends up saving Queensland money.

Ms CAMM: This question probably pre-empts Christian's question to Professor Siskind. Thank you for your submission. It is very thorough. I really enjoyed reading it. I come from a regional centre—and you have done your research because you named Eimeo, which is near where I live. The assertive community treatment model is fantastic. If we had an endless bucket of money, it would be great to roll that out across all of Queensland. Even in the field of psychiatry we struggle to attract people to come and work in regional areas.

If I look at my own HHS, we struggle to get basic specialist services. We have a lot of visiting specialists who come—fly-in fly-out. When it comes to the mental health response and those specialist skills around psychiatry, is the recruitment of people to live regionally and experience face-to-face services regionally the best outcome or are there other ways utilising technology now that we can look at a hybrid model in a sense? As much as I would love for us to have a team, I am realistic that it is very challenging right now to even get health professionals with basic expertise and specialists to come to the region.

Prof. Siskind: I have very fond memories of the Eimeo pub.

Ms CAMM: It is a great pub.

Prof. Siskind: It is a great pub in regional Queensland and I actually thought about working in Mackay because it was so nice up there, but I digress. There are two parts to your question. One is about whether it is worth resourcing intensive psychosocial services that get people out of the mental health service and that save resources for police and other community services. I would argue that yes it is worth resourcing them because it has social benefits to Queensland financially but also to humans. The consumers we serve are functioning better.

The second part of your question was around the challenge of recruiting staff to regional Queensland. With these mobile intensive rehabilitation teams, I may be a psychiatrist but I am by far the least useful member of my team. The useful members of the team are the nurses, the social workers, the occupational therapists and the psychologists, and we can recruit those people to regional Queensland. In fact we should be providing these sorts of resources for Queensland because most of the resources provided in my time are by these great case managers who are providing that one-on-one, side-by-side care around therapies, cognitive therapies, to get people out of the system and they can be managed by support workers.

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Your question is: where does the psychiatrist fit in? You are sitting next to Christian, so doctors are not that helpful, not that useful. Joe would probably back me up on that one. What I am going to argue is that we can do that through telehealth. The medical piece does not necessarily have to sit in regional Queensland. If we are resourcing it, we can provide those telehealth services. The key members of the team are the nurses, the psychologists, the social workers and the allied health, and we can and will attract them to regional Queensland.

CHAIR: I will just put on the record for *Hansard* that I think all members of the team are important.

Ms KING: My question is to Ms Davies-Roe and Dr Hoehn. I want to specifically ask about models of care for perinatal health. Can you elaborate a bit more on that? In addition, could you comment on where investment would see significant gains in the health of the people you work with every day and more broadly as children grow up hopefully into healthy adults? Where can we effectively invest?

Dr Hoehn: We need to think of it as a family unit. We need to invest in the mental health of the parents, and we need to invest in the social and emotional wellbeing and the development of the children. For a small percentage of those, they start quite early with significant issues that also need to be addressed. We also need to invest in a system that supports them as a family, as a wraparound. Some of those are state government responsibilities, some of them are Commonwealth responsibilities, some of them are PHN responsibilities and some of them are just the responsibilities of us as communities or local government and so on.

The key for models is how we can actually bring that together and work together. It is a different way I guess of thinking about the people Dan sees—where you are dealing with a single client who presents with an illness and you are trying to support that individual to move out and have the best quality of life. We are talking here about bringing a system together, even just for the child and the parent, so we need good quality maternal mental health care. We need to be able to assess that to start with, identify it and then have treatment for that, as well as for partners who also require that treatment. We need to be creative in those models.

We fund community mental health positions—because most of this does not happen in a kind of inpatient context. Like Dan, we really want to work to keep people as close to home as possible. When you have little people, it is very hard. Dan talks about it being hard for adults, for individuals, to get to services. If you are taking small children with you or a whole family, that is multiplied enormously. Then we want to be able to home visit, provide services as close as possible to home, and wrapping needs around it so we have a continuum of care that starts antenatally or even before that. If you have someone who Dan is working with who already has schizophrenia, there can be antenatal counselling and before they even become pregnant. In terms of alcohol consumption, all of those things can start before they become pregnant and then move through that life period.

The research is available that tells us exactly what is needed in each life stage. We know what models of care work at each of those points so it is about now thinking how we can begin to invest in those and bring that together. We know about having a home visitor who attends your house. A proportionate version of that might require a social worker to go with a nurse who is home visiting. If we start that in pregnancy and continue that on for the next two years, that makes an enormous difference, and the more vulnerable the population the bigger the return we are going to get from that.

We know that good antenatal care physically will have better outcomes for the baby, for the pregnancy and for the delivery so the baby is off to a better start. We know that if you experience domestic violence in utero there is greater risk already prior to birth of having a brain that is not functioning the same as the brain of a baby that does not experience DV before birth. We know that the relationship between the parents and the child literally grows the brain that the child is programmed to have genetically, and we know we can impact the genetic make-up of that brain by the caregiving that the baby receives. We are already influencing the subsequent generation by what we are investing in here. We know that early education and care experiences as early as possible, particularly for our most vulnerable, will have an enormous return in the longer term for them for education, for their behaviour and for their broader social experiences as well as their mental health.

There is an enormous amount to be gained by investing. We know the models that we need. They are not necessarily all a component within an acute mental health setting or in a mental health setting, but the key is to work out how we can link up a sector that will actually support. Families need housing, just like the patients that Dan has described. It is actually hard when the only housing that is available is apartments and there is no yard. We need developmental experiences for the brain to actually develop. Not only do we need a parent who is engaging with, interacting with and providing social context for a child and that building of the brain; we also need experiences in the broader Brisbane

community. We need parks, we need libraries—our libraries run First 5 Forever programs—and we need those in cultural contexts. We need community input. We need the direct input of families to tell us what they need. As other speakers have said, lived experience, cultural safety and all of those things are important components in all of this because for a baby to feel safe its family needs to feel safe and that is a collective approach. It is very hard to answer your question.

Ms KING: Could you comment on the role of perinatal healthcare workers? I know that Peach Tree does that work. Could you tell us about that?

Dr Hoehn: They have done an enormous job. We have playgroups. In a general population context, we have playgroups because when you have little people you need that level of support. We gain our knowledge and experience by sharing it, by having that collective. There is the concept I said about having a village. The problem is that it is hard. If you have a mental health issue or a mental health diagnosis, if it is hard for you to be present with your baby then you do not necessarily fit in those normal community experiences. It is very hard to join a playgroup. It is actually hard to turn up at a child-care centre and hand your child over in a way that is going to support the child to do that. Often you are terrified of engaging with people; you feel quite dislocated and disengaged.

One of the things that Peach Tree offer is that actual lived experience support. They actually run groups for parents that allow parents to have very similar experiences as they would have in the community but in that much more supportive environment. As Peach Tree have grown, they have added on other services that playgroups would normally have, like sing and grow programs, and their versions of playgroups, and they are also developing referral pathways for the people who attend. They are providing a safe space, led by peers who understand the experience that women and their partners are going through, as well as providing those opportunities for them to parent and for their children to develop the social and emotional wellbeing that they need. They are an absolutely crucial component of this continuum of care that we are trying to build.

We are going from peer-led services at one end to the fact that some of what we need are mother-baby beds, and we have very few public mother-baby beds in Queensland. It is that whole continuum of care that we need to think about. We need to support more peer-led services but we also need to grow mother-baby beds and everything in between. We have four public mother-baby beds. That is not all state government funding but some parts of that are. The centre was set up to really try to connect that service system up. There was a vision at the time that we needed to set something up that acted as a central point to support, whether it is Peach Tree or the Lavender unit, which is the four beds, or whether it is a Step Up Step Down day program that we have put in place in Cooktown or telepsychiatry networks that we have happening in the cape in Far North Queensland.

Each community is different as to what they need, what they can offer on the ground, so that experience is unique for that child. There is enough on the ground in communities if we actually think about what we can wrap together and then we can identify where need is in specific places.

Mrs McMAHON: I want to talk about the NICU experience. We have got a NICU graduate in our house. We spent three months there. You were saying earlier that postnatal depression affects one in five mothers, and I would imagine for women and families who go through the NICU experience, given the trauma of birth or the trauma post birth, that would be significantly higher. Are there any particular programs, welfare programs or mental health support for parents and the children in that period post NICU discharge and through those early years if they are at a higher risk of postnatal depression?

Ms Davies-Roe: In terms of the programs, we may need to take that question on notice to come back with detail around that. You are exactly right: there are increased vulnerabilities for both the mother and the baby within that NICU setting. From a physical health point of view, I know that the hospitals where those NICUs are placed often have allied health and nursing. The allied health is there to support the mother, the father and the baby in terms of working through that at-times quite traumatic arrival that was obviously early and very unexpected.

There are processes within that setting. Obviously, though, like in other areas, as the baby grows and is able to step down into less intensive care, those referrals will follow. In terms of the prevention of postnatal depression, it really is again about that allied health and screening and being able to identify the need and provide that allied health support. If we could take on notice the question about providing a formal response about the particular programs around NICU, we will certainly provide that.

Dr ROWAN: I refer to the Queensland Centre for Perinatal and Infant Mental Health. There have been a lot of discussions about adverse childhood experiences and complex trauma. The chair talked about substance use, particularly in pregnancy, and alcohol foetal syndrome. Comments were made before about population health solutions and you referenced parks, libraries, providing people
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with employment and educational opportunities and all of those elements compared to providing the clinical services at the other end. I know that Mental Health Commissioner Ivan Frkovic has done a lot of work in relation to strategies that talk about population health solutions and things. From the centre's perspective, can you advise the committee about specific strategies that could assist in that space in relation to prevention and building resilience not only in communities but also within families to provide opportunities to prevent some of the other issues that emerge down the track?

Dr Hoehn: I think messaging becomes a huge factor—communication at every level—if we are looking at population health. The whole adverse childhood experiences area, particularly in the US, has built a movement, I guess, that is really trying to get that message out incredibly broadly. There is a paediatrician who is championing that on the west coast in San Francisco. She has really driven this as a population health agenda. The Harvard Center on the Developing Child has developed a whole series of resources to support that kind of process—video clips, all sorts of things. They are intimately involved with getting that message out. On the back of that, that has been picked up by a philanthropic supported organisation in Canada, the Alberta Family Wellness Initiative. They have taken that message of adversity and turned it around into brain building. They have gone with this very strong focus on building brains to actually create a difference. That is a whole-of-population approach that they are taking. They have created all sorts of videos. They have created a language that they can share with population. It is something that can be used both at the treatment end and also at getting that very broad general message out. ARACY is looking at adopting that in Australia. In Queensland specifically, there is a group that has come together in collaboration with ARACY, the children's hospital, that are looking at how we can really develop and get that brain builders message out. It is about things like that.

Clinically, I teach even three-year-olds about the brain, how they can manage their brain and build their brain. It is a very straightforward, simple message we can get out there, but it is also that message about the fact that you can have this enormous impact to overcome adversity; that you do not have to be stuck in adversity; that we can build resilience. That is really at the core of the public health messaging that goes out: how we can make a difference in the early years space but also right across the life span because we have plasticity. That is one example that is kind on the horizon. QUT is also quite actively involved with the group in looking at how we bring that message to Queensland.

CHAIR: With that, I thank Ms Davies-Roe and Dr Hoehn for their presentations this afternoon. I thank Professor Dan Siskind. Please pass on to the nurses my regards, Dan. I am very fond of them as well as I am sure are all members of the committee. We acknowledge and thank all of you here today and your teams for the great work you have done over the past two years in dealing with a very significant health challenge for our entire world. It is great to have a state with a really robust health system. The information that you have shared with us this afternoon will be invaluable to the committee. We do thank you for taking the time to appear today. The committee may choose to send some additional questions through to each of you for things that we would have liked to have asked this afternoon but did not get to. I note a number of questions were taken on notice. We would like the responses to those back by 18 February. We have cut your session a little short because we have one presenter who was not able to make it and we have brought some other presenters in slightly earlier. It is Friday after all! Thank you very much.

Proceedings suspended from 3.05 pm to 3.15 pm.

AH KEE, Mr Bevan, General Manager, Queensland Aboriginal and Islander Health Council (via videoconference)

ANDERSON, Ms Kimina, Director, Aboriginal and Torres Strait Islander Health, Aboriginal and Torres Strait Islander Health Division, Queensland Health

FAGAN, Mr Cleveland, Chief Executive Officer, Queensland Aboriginal and Islander Health Council

GROGAN, Ms Haylene, Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General, Aboriginal and Torres Strait Islander Health Division, Queensland Health

CHAIR: We will reconvene the hearing of the parliamentary inquiry. I will start by reaffirming our acknowledgement of the traditional owners of the land on which we are holding this meeting. Thank you all for coming along today. I will ask each of your organisations to make a briefing opening statement and then we will go to questions from the committee members. Ms Grogan, could you kick off with a brief opening statement?

Ms Grogan: With permission, Chair, I would like Cleveland to go first out of respect for our community.

CHAIR: Absolutely. No problems at all.

Mr Fagan: Thank you, Mr Chair. I start by acknowledging the traditional owners of the land on which we are meeting today and also extend that respect to the other Aboriginal and Islander people in the room with us today. I also thank the committee members for their interest in an area that is often put in the too-hard basket. My hope is that there are some tangible changes to this part of the health system that will bring better outcomes for Aboriginal and Islander people.

We represent 31 members across Queensland in community controlled organisations that deliver comprehensive primary health care. Our key focus is around identifying and addressing the causal contributors of chronic disease and health issues that our people face. We try to do that before they become complex and need access to the secondary or tertiary parts of the health system. This requires us being able to understand and assess the needs and then being able to refer off to the appropriate parts of the health system.

What we are finding is that we know that mental health is one of the areas where a lot of people fall through the gaps—from the early part around intergenerational trauma and personal family relationships right through to suicide and the need for the acute part of the mental health system. We know in Queensland we are not on track to meet Closing the Gap. The key measure in Closing the Gap around improving life expectancy and the other 16 Closing the Gap measures can all be indirectly impacted if we get the parts around mental health and social and emotional wellbeing sorted out right.

When we prepared our response and submission, we consulted with all of our members across Queensland to look at the key issues that they face and the things that we wanted to provide to the committee today that will help us to bring about change in the future. We know that the current system does not recognise the whole continuum of mental health that we as a community controlled sector focus on. It does not take into account the work that we do around social and emotional wellbeing, around family wellbeing, around helping people to deal with family relations, anxiety, depression and all those types of things. We see that the health system only picks up when people are needing to be looked after under the Mental Health Act or brought down and put into mental health facilities to help deal with an acute part of their disease.

Our members identified an extreme fragmentation and lack of accountability in the mental health area and we felt that a lot of the people we deal with fall through the gaps. The only time that we then really see them is either when they are being admitted into the facilities or when we are attending their funerals at the end of the day. Under-resourcing and challenges around accessing workforce have a really big impact. It is about the health system not really understanding that there are community developed solutions that will really make a big impact and that incorporate the cultural and community constructs in the communities in which we work. The problems that we face are not new. Our community controlled sector has been experiencing and working on these challenges for decades. Despite the huge systemic challenges, we have been able to meet the needs of our community and are trying to do the best with what we have.

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One of the things that we really wanted to get across in terms of a way forward is the understanding of that whole continuum. This happened when we had an incident where a community member in one of the communities in Cape York drove a four-wheel drive through a house and killed people in the house because he could not come to an agreement with his partner's family around a burial and the cultural parts of the funeral. When we went up there with Dr Ernest Hunter, who is very well known in the mental health area, we worked with the Torres and Cape HHS on a model based on mapping people's needs against the bell curve of low, medium, high and extreme. The low and the medium is what we in the community controlled sector would deal with through counselling, family wellbeing programs, social and emotional wellbeing. The extreme and high categories are the people who are taken by the RFDS down to the mental health facility in Cairns. We are saying that a way forward is if there is a shared understanding around the mental health continuum that includes what we do in primary health care—we know what we need to do in terms of our primary healthcare space—and there is a clear referral pathway into the more acute part of that mental health continuum.

The other big issue in terms of a way forward is around a lot of funding for mental health services and social and emotional wellbeing services that is provided to mainstream non-government organisations, which then come in and deliver services. Our people do not have much of an uptake around that because it is not appropriate. The people delivering the services do not really know the connections, culture or gender issues that we need to deal with. Therefore, they do not access. As a result, we see them in the back of the ambulance or in the mental health facility or when we attend their funerals.

Those are basically the key messages I wanted to get across in my opening statement. We know there is significant work that needs to be done. It can be achieved through real partnerships. That is why we are sitting here with Haylene from Queensland Health. I think the health equity agenda that we jointly delivered is one of the best tools that will give us a clear understanding of what we really need to do to not only deal with mental health and link it into wider social and emotional wellbeing but also put that in the context of how we deal with better health outcomes overall for Aboriginal and Islander people.

CHAIR: Thank you very much. Ms Grogan?

Ms Grogan: To start, I will acknowledge the cultural custodians of the country we are on today, the Turrbal and Jagera peoples. I also pay my respects to elders past and present and, in particular, thank my elders who have given me the opportunities I have today. I stand on the shoulders of my predecessors. The work I do every day is a privilege and is to respect and honour the foundation they laid for us.

My name is Haylene Grogan and I am Queensland Health's inaugural Chief Aboriginal and Torres Strait Islander Health Officer and Deputy Director-General. I am a proud Yalanji and Tagalaka woman on my father's side with Italian heritage on my mother's side. I am privileged to be invited as a witness to talk to this committee today. To be honest, I am a little nervous, which is unusual for me. My nervousness is because this topic is very important to me.

I have invited Kimina Anderson, my long-standing colleague and Director of Aboriginal and Torres Strait Islander health in West Moreton Hospital and Health Service, who unfortunately in the past 12 months has experienced too many suicides in the region in which she works. Importantly, she led the development and publication of *Inside out: the mental health of Aboriginal and Torres Strait Islander people in custody report* in 2012. That was one of the first reports that reflected the actual voices of Aboriginal and Torres Strait Islander people in custody and the very first mental health report that I had the privilege to approve and sign in my previous role.

Thank you for this very much welcomed opportunity. Although I am confident we have the right leadership, the genuine commitment and a strong intent across the health system in Queensland to improve the delivery of health care, including mental health care, and to make it culturally safe and responsive, it is yet to be the reality on the ground. But it is our aspiration. My colleagues from Queensland Health and the Mental Health Commission have already attended as witnesses and outlined the challenges across the health system in delivering effective mental health services for all Queenslanders. I support what they have said but I will try not to repeat everything they have already said. I will say, though, that all the challenges, complexities and difficulties described by my colleagues are compounded and amplified for First Nations peoples.

We First Nations people experience and confront all the same challenges, complexities and difficulties that every other Queenslanders faces, whether related to family, work, health, relationships, financial security or global pandemics as we are currently experiencing. Life is challenging for all of us whether we are black, brown or white. However we, the First Nations people of these lands and Brisbane

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the many nations we cover, also experience challenges, complexities and difficulties from our colonial history and the ongoing trauma that this has had on our families, our extended kin, our communities and our connections to culture, country and each other. Every day experiences are compounded by this additional layer until we heal, which is a process that is ongoing. It is the impact of racism and discrimination on two distinct and proud cultures, Aboriginal peoples and Torres Strait Islanders. We can have a less confronting discussion about cultural capability or cultural safety, even though they mean the same thing. A culturally safe or a culturally capable health service is one that is not racist, and we need more of them.

Good practice is yet to be common practice, because we still need more culturally safe and responsive models of care, services and organisations. Many First Nations people still describe our health system as racist and culturally unsafe. Our data shows First Nations people commit suicide at higher rates than non-Aboriginal and Torres Strait people and are more likely to be hospitalised for psychoactive substance use and psychotic disorders. Mental health and substance use disorders are the leading contributors to the burden of disease for First Nations Queenslanders and are now ahead of cardiovascular disease and cancer. That is an extraordinary finding and means the main causes of ill health that we experience are tied to our social and emotional wellbeing, how we feel about ourselves, our place in the world, our communities, our cultures, our country, our languages. Health for us means all of those things. They are interconnected and our mental health is a litmus test on how we are travelling and being treated clinically and culturally.

The solutions are not simple, but only we can tell you about our lived experience and what we need to stay well, to be well and to get well. While the health system cannot address all the social injustices, we can ensure the right care is available to support First Nations people to overcome mental health struggles. To be successful, these models and pathways need to respect and value all Aboriginal and Torres Strait Islander cultures. To do this, we need our people in the system, our voice in the system and a better coordinated system, including with the other determinants of health, as Cleveland said. My role and responsibility is to partner with leaders across the health system in Queensland, including with my respected colleagues here today, Cleveland Fagan, Kimina Anderson and Bevan Ah Kee, who is online.

Our goals are big: to achieve health equity, to eliminate institutional racism and to attain life expectancy parity by 2031 by reforming the health system to make it culturally safe and by addressing the avoidable and unfair health inequities that exist for too many of our people today. Our health equity reform agenda, as Cleveland referenced, is underpinned by legislation changes passed in August 2020 and April 2021. It is about reshaping local health systems with First Nations people. First Nations representation that is the voice on each hospital and health board is now a legal requirement, along with our first-ever health equity strategies, which are being co-designed by each of our 16 HHSs, with the community controlled sector, our First Nations staff, local elders, traditional owner custodians and community. That is also a legal requirement. Each HHS is legally required to have a First Nations workforce—that is, our people—proportionate to the First Nations population they serve across every workforce level and every workforce category. Our reforms to achieve health equity, that is, designing and delivering health care with First Nations people, is historic. It not only includes improving mental healthcare services but also improving the coordination of those services. Significantly, each HHS is now also legally required to deliver culturally appropriate health care that First Nations people need and want.

To conclude, I will share three final things: firstly, two successful examples of First Nations-led and designed mental health services, the Sit, Talk and Yarn project in Cherbourg and the Way Forward Project in Brisbane; secondly, I have been given permission to share some insights from two of my Aboriginal work colleagues who experienced challenges trying to access culturally safe mental health care with their children; finally, I will share personal experiences from my family.

The STaY project, the Sit, Talk and Yarn project, was jointly developed by the Darling Downs HHS and the Cherbourg Aboriginal Shire Council in 2020 when Cherbourg was in crisis from multiple suicides—mostly young people aged between 15 and 20 years. Despite the numerous services being provided at the time, there was no suitable early intervention mental health or outreach services available to support the devastated community going through that crisis.

The project had three key success factors. It was First Nations led, co-designed with the community to meet the needs of the community and strongly supported by the community. It was innovative. It was a 24-hour hotline, so access to mental health support was available during any time of crisis whenever it happened. It also built on community capacity by giving residents and families tools to respond to mental health crisis when they happened and this has continued to be expanded to support first responders.

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The second project, the Way Forward project, was co-designed with the community controlled health sector, local elders and our Metro South HHS because Aboriginal and Torres Strait Islander people, feeling culturally unsafe, were not accessing care when they needed it and discharging themselves early or not complying with clinical directions. Patients, their families and carers reported to be feeling safe by having First Nations mental health workers—that is, our people—available to provide cultural support which, in turn, led to better health outcomes for them. This reporting was due to an improvement also in the quality of the data captured about the type of cultural care provided.

Previously the client database had no functionality for Aboriginal and Torres Strait Islander mental health workers to describe the cultural care they provided. It was a generic one liner that stated 'cultural support'. Now the type of cultural care provided to patients is valued as a vital part of their care plan, whether it is about sorry business, connecting to family or country, or supporting patients dealing with trauma. The care model recognises that effective care requires both clinical and cultural aspects. They go hand in hand.

I will now share some personal insights from my two work colleagues. They are both tertiary educated families in middle to high income brackets. Based on their lived experiences over the past few years they have suggested the follow improvements, not vetted by me.

Employ psychologists and psychiatrists in Aboriginal and Torres Strait Islander community controlled health services because they are culturally safe. Locate Aboriginal and Torres Strait Islander hospital liaison officers in emergency departments to help First Nations people experiencing an acute mental health crisis. Value the role of First Nations healing practitioners, whether they are psychologists, psychotherapists or counsellors. Sometimes our healers are not valued by mainstream health professionals.

Invest in 24-hour crisis lines with trained and available Aboriginal and Torres Strait Islander staff. Ensure all medical staff have basic mental health, cultural capability and 'anti-racist' training, because invalidating cultural experiences is very distressing for First Nations people. Increase the number of beds for mental health in the public health system—both long-term inpatients and short-term emergency stays.

Ensure mental health clinicians have a better understanding about cultural trauma and the relationship between mental health and cultural identity. Ensure access to culturally safe spaces, First Nations mental health workers and First Nations healing in psychiatric inpatient facilities. In summary, they have both said we need our people in the system and we need a more culturally responsive system.

To finish, I will share a little bit about my family. My father grew up in Mona Mona, an Aboriginal mission in Far North Queensland, where his parents—and Cleveland's grandparents—were both stolen and moved to. At the age of five, he, like all children, were taken off his parents and placed in the dormitory under the control of the 'protector' and could only see his parents two hours a week on a Sunday. Can you imagine that? Two hours a week!

My dad used to sneak out at night—I only recently told Cleveland this story—to lay next to his mother and then sneak back in the early morning. I think that helped him emotionally as he is the only male sibling of five who did not drink alcohol or smoke tobacco. He also, like the rest of the Mona Mona mission, had to apply for an exemption/permission to leave the mission. I have to show you this. I have showed it before publicly but it is important to me. I have the original certificate of exemption that my dad had to apply for—him and my aunty—to get exemption to leave the community.

It has been interesting to see how the Australian community has reacted to recent COVID-19 public health restrictions compared to the far worse controls that our people endured for many decades. The stolen generations affected the social and emotional wellbeing of First Nations people across the country and across generations in countless ways. It is our living history; it is not the ancient past. My dad will be 79 this year and his experience is part of our lives and who we are as people. It is because of this history that I chose to work for government, to influence the very policies and laws that used to control my father's life and our First Nations people's lives.

To sum up, I strongly propose three priorities that will improve mental health—all health—outcomes for First Nations people. We need our people in the system. More First Nations peoples need to be working across the system from mental health prevention and promotion to specialist clinical roles right through to health system leadership roles. This is how we will create a culturally safe mental health system by embedding cultural ways of doing, knowing and being into clinical practices and healthcare provision.

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We need our voice in the system. Aboriginal and Torres Strait Islander people have to have a say on the way mental health service models and pathways are led, designed and delivered. We are the experts of our lives.

We need a coordinated system. We need a better coordinated and integrated mental health system that invests in the 'missing middle', as Cleveland talks about. We need to integrate mental health care into primary health care and provide better coordinated holistic care.

Thank you for your time today. I look forward to answering any questions you may have for the remainder of the session. I am sorry. I read it three times this morning and held my emotions but did not then.

CHAIR: The emotions are totally appropriate and accepted by the committee. We echo the apologies that have been made by other parliaments about the stolen generation. Thank you for sharing that. You showed us some documents there. If you would like to table them, we could copy those and table them for the record.

Ms Grogan: Absolutely.

CHAIR: I would like to start by acknowledging you as the first Chief Aboriginal and Torres Strait Islander Health Officer. I am old enough to remember the first chief nursing officer. It has made a great difference to our profession. I think it is great that you have that role and you have a big responsibility. I can see that you are doing an excellent job fulfilling that role. I would also like to acknowledge the Indigenous liaison officers I have had the pleasure to work with, unfortunately not until quite late in my career. They made a huge difference to my practice, hopefully delivering more appropriate practice but, more importantly, helping people who identified as First Nations people to receive the care that they needed.

I would like to start with a question to Mr Fagan. Thank you for your submission. You mentioned in your introduction that NGOs were funded to come into a community and deliver services. Who funds those services? Do those services attempt to try to engage with the local community in the planning and development of those services or is it more that they just come in and say, 'This is the model that we are going to implement'?

Mr Fagan: The whole Aboriginal health is a very competitive environment. We have to compete with not only other community controlled organisations but also non-government organisations like Mission Australia and other NGOs like that. In most cases we only find out about the work that they are doing when they come into our communities to deliver the service and ask us to do things that will help them to achieve their outcomes. We find that there is no involvement in the design of the program. There is no involvement in the planning. In most cases they will actually try to employ local people but under a model of care that is not appropriate or designed for Aboriginal and Torres Strait Islander people.

All we are saying is that everyone has a role to play. If funding, mostly given by Commonwealth and state governments, is going to be provided, then at least involve us or community in the design because how you deliver it in Yarrabah is going to be different to how you deliver it in Brisbane, Cairns, Aurukun, Charleville or Mount Isa. At the end of the day, we acknowledge that we cannot do this alone. We have to work together, but we know our community. We know what is needed to be done and how to deliver it in a way that is going to maximise the outcomes on the ground.

CHAIR: Member for Traeger, did you have a question?

Mr KATTER: I did not write down the comment that was made, but there are challenges with engaging the right people. Often in my area the locals in communities like Doomadgee are not qualified but work in that space—say, ATOD officers and things like that that connect into that mental health area. All the compliance that surrounds those roles is usually a barrier to most of the people who can cut through to a lot of the people you are targeting. They are not clinicians by any means. That seems to me to be the constant challenge to getting some meaningful engagement in some of those tough areas like Doomadgee where it is hard to cut through. I would like you to comment on that because I see that as a really big challenge. I would love to see more of those positions filled by locals or at least someone from an Aboriginal background who has that connection and can cut through. I see that as one barrier anyway. Has that been your observation as well?

Mr Fagan: Chair, how do we refer to members on the panel?

CHAIR: You can refer to him as 'member' or 'Robbie', if you know Robbie.

Mr Fagan: Robbie helped us when I worked with the Apunipima Cape York Health Council. He was instrumental in helping us to navigate the system to get what we needed. The comment that he referred to was that people working in the mental health and social wellbeing area at the moment Brisbane

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have to have certain qualifications to do it. Yet, when Haylene and I were growing up in Kuranda, there were people in our community who had that natural and cultural tendency and people went to them to talk to them. Bevan's father was one of those guys you could go up to and have a yarn about anything.

What we were trying to do was based on some of the work that was done at Napranum up in Cape York, where Ernest Hunter worked with community to develop a program called Natural Helpers. That was about recognising the cultural roles that certain people play but then giving them the tertiary qualifications—a diploma in counselling and the like—and recognising their role in community by then putting them on a retainer so they had a job, they had respect and they had cultural standing. They were providing for their family. More importantly, they were then able to navigate the cultural pathways between communities.

When I first started at Apunipima we had a suicide on Australia Day in 2006. We had to pay over \$50,000 to get counsellors into Coen to provide counselling for three weeks. Then they left. They flew back to Cairns on the weekend. We only had access to that counselling between Mondays and Thursdays. The Natural Helpers program that we developed and then tried to shop around to get funding meant that there could have been people in Aurukun or Lockhart River who had cultural ties to Coen who could have been brought down there for a much smaller amount and they would have the cultural connections and the respect to be able to sit down and yarn not only up until when the person is put in the ground but when people really need them, which is afterwards. They would be able to deal with family disputes and community disputes.

Robbie referred to cultural appropriateness, and that is what we are talking about. In Doomadgee and Mornington there would be people in community who would have that kind of role. We recognise that we need to get the counsellors and clinicians like Ernest Hunter, but there are also people who have done that type of work in our communities for generations. If we are able to get acknowledgement of that and flexibility for them to operate and to understand the role that they play in that health continuum, then we would be able to get the appropriate services that our people need.

Ms Grogan: Can I offer a response from a government perspective. Aboriginal and Torres Strait Islander health workers and health practitioners are the smallest clinical cohorts of our workforce. Over a third—it might be even half—are nurses, doctors and allied health people. Our Aboriginal and Torres Strait Islander health workers are the smallest component, but what is most important for our communities is that they are cultural brokers. You are absolutely right.

The opportunity we have now is that not only have we got in the regulation that every HHS has to have an Aboriginal and Torres Strait Islander workforce proportionate to the number of people in the footprint they serve; the government has given an election commitment to develop a health workforce strategy for Queensland. It was for Queensland Health. The minister, with the Premier's permission, has broadened the scope. QAIHC, the Queensland Aboriginal and Islander Health Council, is working with the community controlled sector to develop a health workforce strategy for Queensland. It is massive. It is a big opportunity.

We are not going to write another strategy. We have a lot of them and we have lots of learnings about what we need to do. We are going to write a strategy for action. We have a draft concept paper that we are about to release together once we both sign off on it. It is a package of actions. Within Queensland Health we have for the first time a certified agreement for our Aboriginal and Torres Strait Islander health workers that allows us to get some clear role delineation.

More importantly, Robert—I do not know you; I know your dad—the one thing we have not done is invest in health worker training and professional development. There has been underinvestment in that over the years. If you are a young person in school and you want to be an Aboriginal and Torres Strait Islander health worker you would not know where to go. I was a health worker with Wuchopperen. That is where I started my career. I became a nurse because I did not have any formal training.

We have to put some investment into training provision that is statewide and locally accessed for our local people. The one portfolio that does it well is the Ambulance Service. They have a lot of local people employed in the Ambulance Service. They do it really well and they keep them. They are a registered training organisation.

I do not know if Kimina wants to comment because she has been around mental health for a while and she could speak to the qualifications there. We will have a lot of opportunities to answer more questions, but it is a pertinent question.

Mr MOLHOEK: It would be remiss of me not to acknowledge the traditional owners. I point out that I am the co-chair of the Parliamentary Friends of First Nations People. I am not Indigenous, but I think I am the only one on our side Leeanne Enoch was comfortable grabbing for the role. I have had the privilege of visiting Kowanyama. It is a beautiful spot on the cape.

You said, 'We need our people working everywhere in the system.' You talked about some mandatory requirements around every health service having a proportionate number of people. Can you expand a little on that policy and what that means or looks like? Has it been formalised or is it a broad goal in a strategy at this point?

Ms Grogan: In August 2020 the Hospital and Health Boards Act was amended to require every hospital and health service to develop health equity strategies co-designed with the community and a whole lot of development stakeholders. It also requires every HHS to have at least one Aboriginal and Torres Strait Islander member on their board. The regulation to support that amendment was passed in April 2021. That regulation spells out some more detail about what is required for every HHS. One of the requirements is that they have to have an Aboriginal and Torres Strait Islander workforce proportionate to the number of Aboriginal and Torres Strait Islander people they serve in that footprint. Obviously that is not going to happen overnight and will take a fair bit of work. The government's election commitment is complimentary to achieving that.

The first of the equity strategies that every HHS will be developing has to include what they are going to do about achieving that. I dare say most of them will look at a 10-year trajectory because we have a commitment to 2031 to close the gap. In Queensland I think we have the best chance of doing that—I am looking at Cleveland—because we have the best community controlled health sector. I truly believe that we have the best leadership in health in the whole of the country. I think we will set a very good foundation for the next 10 years. None of the leaders currently sitting in the health system want to look back in 10 years and not know that we have made a difference.

Getting back to your question: the regulation spells out what is required. What we will do in Queensland Health is ensure that the service level agreements signed off by every HHS commit to what they have to achieve. As the Chief Aboriginal and Torres Strait Islander Health Officer, I will be signing off on all those health equity strategies. I will not be signing off on any of them unless they show that they are meeting the requirements of the regulation and it has been co-designed with the community control health sector.

Mr MOLHOEK: Maybe it would be good to get a brief from the department on what that regulation is. Maybe someone can dig it up and resend it to us.

CHAIR: We will dig that up internally.

Mr MOLHOEK: It would be good to have a look at that. In terms of meeting that requirement, it means we are going to need to see a lot of Indigenous or First Nations people trained. I think Cleveland touched on the fact that there needs to be a bit of a look at some of the training. I think Robbie Katter also touched on the issue of how we get qualified people. I would be interested to hear your thoughts around what programs are in place. I know Griffith University on the Gold Coast, for example, has about 3,600 Indigenous young people in their programs out of the 40,000-odd students they have. Not unlike non-Indigenous kids, a lot of those kids go to the Gold Coast and Brisbane and they do not really want to go back to rural and remote areas of Queensland. How are we going to get people trained? How are we going to make sure that they want to go back and work in rural and remote areas?

Mr Fagan: That is an important question. We have to look outside the health system. Prior to coming to QAIHC I worked in Yarrabah looking at the social issues. We worked with the Yarrabah Leadership Forum. One of the things we worked out there is that we need to start at the primary school level within the school system in channelling kids into health as a career choice whilst recognising that to do that effectively we then need to deal with the intergenerational traumas that the families have. That is one of the biggest barriers. People do not see education as an issue because they have gone through trauma early on in their lives or their parents have. We need to deal with that and get the family in the right frame of mind and get them the house and the safe space they need.

We then have to work with the schools. We did a lot of work with Tony Cook, the previous DG, in Yarrabah—and this has been picked up with interest by other Aboriginal councils around Queensland—around getting into the school and developing the kind of curriculum that kids are willing to engage with. In Yarrabah the school only goes up to grade 10. We have a cohort of about a third of the kids who go to the secondary school who do not turn up. Out of a 200-day school year they might turn up for 20 days. We had to look at alternate ways of getting them interested if they do not learn in four walls.

We have linkages that we are developing with the local junior rangers. We were looking at the Steiner model where you take kids out of school and teach them maths by getting them to build a pizza oven. It is starting and engaging with people and involving people like Dr Mark Wenitong. People think that medicine is too hard and they cannot be a doctor. My daughter is a third-year paramedic student at CQU and almost has a place to do medicine at Bond University.

I grew up on a mission. How do we take the opportunities that we had and apply them to people living in DOGIT communities, rural communities, Brisbane, Charleville, where Robbie lives up north? What are the key learnings that we can apply? It is about getting the family space right, getting the education system right—a structure where people want to go to school—getting health bedded down as part of VET training in schools and giving people pathways to get into TAFE courses to do enrolled nursing and then transition into university. That is the way over the next 10 years that we can build the workforce that is going to give that equity of workforce within the HHSs.

Mr MOLHOEK: Do you see the Cowboy House model in Townsville as a good model?

Mr Fagan: Yes, Cowboy House, Clontarf—all of those. We have Clontarf in Yarrabah. We had a partnership with Johnathan Thurston. It is those kinds of people who will create the hook for people to get engaged, but we have to work with families. We have to get the school system right. We have to get kids wanting to go to school. If they are not learning in a typical way then we need to create opportunities for them to maintain that interest. Education is the key. I grew up in Kuranda. I had the opportunity to go to university in Adelaide. I finished my training at a university in America. Everyone should have that opportunity regardless of who they are and where they live.

Ms Grogan: I was going to say the same. It starts in the schools. It is always about financial support and then wraparound support for the family. The reason programs like Clontarf, Cowboy House and others work is their design.

Ms KING: I want to acknowledge you all. Thank you for being here, particularly Haylene. I want to acknowledge the huge pride that Haylene's community finds in her role.

Ms Grogan: My aunty is in your electorate.

Ms KING: Yes, I know. I know her very well. She is a wonderful leader in our community.

Ms Grogan: Aunty Flo.

Ms KING: Both myself and the member for Southport are involved with the health committee's inquiry into GPs, allied health and a range of other largely primary health matters. The issue that comes up time and time again is the workforce and growing a local workforce. Clearly you have already made some comments around that. Haylene, you mentioned that you had to go and become a nurse because as an Aboriginal health worker there was no pathway and no training. If you could wave a magic wand what would that training be or look like or does it already exist?

Ms Grogan: No. The qualifications exist in the VET sector. The package and the competencies are there. What we do not have is the money for training providers to provide the training. I hope I get this right—I can take it on notice to get more detail for the committee—but I think there are four or five training providers who can provide training but only two in the whole of the state are. I cannot remember the two.

Ms KING: Do you know whether JCU provides it?

Ms Grogan: JCU was providing training, but not being able to provide training that is closer to where our mob live and work is the challenge. If I had a magic wand I would invest in training infrastructure that would allow health worker training across this state. It is a difficult thing because you need to have registered training organisations that are qualified, but then they need the resources to deliver the training.

The Institute for Urban Indigenous Health is an RTO in the south-east corner that provides training, but it only covers the south-east corner and not the whole state. An institution like the Queensland Ambulance Service that has good training infrastructure does not have the resources to provide training for health workers. If they have the health worker packages they need the resources to deliver them. If I had a magic wand I would invest in the training and development of health workers.

It is only a small workforce. There are only about 400 people. I should get those figures for you as well. Ten years ago, before I left health and came back, we had about 600 health workers. The figure has gone backwards in terms of health worker numbers. I will get the proper data for you. If I had the money I would put it into training infrastructure. Cleveland is absolutely right: creating health careers needs to start in our schools—whether it is gardeners or surgeons, because it takes a lot of people to run a health system. It is about making money for our mob to access the right training from school age, like Cleveland said.

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For our mob, getting to university or gaining tertiary qualifications is always about financial support, accommodation and wraparound social support. That is what we struggle with. If you go back and map our careers out, I bet we had financial support and/or wraparound support available to us. I know I have. I have been able to get onto programs to advance my career.

Ms KING: I think the reason people keep raising JCU is because they deliver their training in 16 different regional locations. They try to find people in community. I just noticed the correlations with what you are talking about.

Ms Grogan: Yes, absolutely.

Ms KING: It would be interesting to find out more about that. Thank you so much.

Dr ROWAN: First of all, Haylene, can I congratulate you on all the work that you do as Queensland's Chief Aboriginal and Torres Strait Islander Health Officer and as Deputy Director-General. I acknowledge your dedication, passion and commitment, which were clearly outlined in your opening statement.

You referenced the health equity strategy that is being implemented and includes the representation of Aboriginal and Torres Strait Islander people on the hospital and health service boards, as well as those service level agreements that have been put there with the regulation, which is the enforceability mechanism to help close the gap. I want to ask how that is aligning with all of the other workforce strategies, particularly within Health, whether it is the Office of Rural and Remote Health or whether it is the strategy, policy and planning division because they are all looking at various things. Is the work that they are doing, which is analogous or already parallel, being wrapped up into those service level agreements as well?

I ask that because it has been noted over the years that particular hospital and health services, from a workforce and service delivery perspective, sometimes look at it being more cost effective to transport people to other HHSs, particularly from some of the rural and remote ones, when it would actually be more appropriate for people to be provided care closer to home. It may be better to have workforce development strategies done together, whether that is for medical, nursing, allied health, Aboriginal and Torres Strait Islander health workers and others.

Ms Grogan: That is a complex question. The HHSs have to each deliver a health equity strategy in addition to what they each have to do to meet the targets, what they agree on. They have to work that out in terms of the populations and sometimes they can quantify them. I think Mackay HHS, without just pointing to one, has identified they need to get 60 Aboriginal and Torres Strait Islander people to meet their target across different categories. That will not happen overnight. In their agreements they are going to have to get that number right and they are going to have to set out how they will do that. In the centre, in the Department of Health—as you know, the department is separate to the HHSs—we will have to do a piece of work to provide the overarching policy support or statewide strategies to support each and every one of them to be able to do what they need to do, so we have a big role in the department. Given that we have the government commitment to deliver a strategy for the health system—massive—we have to work with the community controlled sector. Cleveland mentioned Dr Mark Wenitong. I do not know whether I am answering your question here, but our mob do not care if Dr Mark Wenitong is working for Queensland Health or the community controlled sector because the net effect is the same; it is still the health system.

I might take this opportunity to go a little bit off the mark to say that on the equity reform agenda we are progressing up north two really important initiatives. I can talk about the integrated care—I think we are calling it 'connecting care'—where we are working with the community controlled sector to have like a concierge or program management team to actually facilitate and support health care from the home into the hospital and back for the Torres and Cape region no matter who is providing the care. Whether it is the community controlled sector, Queensland Health, the HHS and/or the GP, that coordinated care is coordinated for that patient to support the patient's journey.

What I am saying is HHSs have to deliver each of their strategies individually, but there is a role for collective statewide stuff that the department has to do and there is also a role for the collective critical mass at a regional level that has to work. There is a fair bit of work to make sure that it all happens. I doubt if I am going to be playing a compliance driven role with this first round of equity strategies. My main interest is to see how strong those strategies have been developed with the community controlled sector and the community so that we can see that the local people, as Cleveland said a couple of times, have had input into that. I went off the mark a couple of times there. There is so much I want to say.

Ms CAMM: Thank you very much for coming along. I too pay my respects and I extend them across my community to Australian South Sea Islanders. I have one of the largest populations in Queensland in the Mackay community and they do amazing work alongside First Nations and Torres Strait Islander peoples.

You talk about the importance of the co-design model and a place based approach. I am very passionate about social development and community development. This question could go to either/or. Do you think there is a lack of recognition by all levels of government when it comes to that co-design model? I think of physical infrastructure that governments think of, such as design and construct a road or a building, but we do not look at that when we look at social infrastructure or maybe service delivery.

What do you think some of those barriers are that need to be overcome so that a place based solution is created to ensure that we are delivering a better service on the ground with local people who know their local community and who have the expertise, rather than the large NGOs that tend to fly in and out? I say that because when I have travelled to Mount Isa and spoken with NGOs or even government departments, they are only there from Monday to Thursday; they are not necessarily there when there is the greatest need for service delivery. What do you see as the barriers at all levels of government? Is it in procurement policy? Is it a lack of understanding and awareness or a lack of resourcing? What are the barriers that we could recommend government push aside?

Mr Fagan: I actually facilitated consultations around health equity over nine weeks in Queensland. One of the things that I struggled really hard to do is to get people to understand that health equity is only one part of a longer 10-year journey towards closing the gap. It is the changing of that mentality.

For a lot of the HHSs and community controlled services, all they think about is what they have to do over the next three months, six months and 12 months. When we look at that 12-month journey, we have to reduce the difference in life expectancy by 7.4 years over 10 years. If we work it back: in six years it will be about 5.4 years; in three years time, 2024-25, we have to be able to demonstrate that we have improved Aboriginal and Torres Strait Islander people's lives by 2.7 years. We know the reasons why people are dying and why people are hospitalised. There are five key areas: heart, diabetes/kidney, cancer, falls and then suicides.

The challenge that we put to the HHSs—and Haylene and I met with chairs of the HHSs, chairs of community controlled organisations, CEOs of HHSs, we met with HHS planners and Aboriginal and Torres Strait Islander leaders. We said to them that you need to take your HHS level data and you need to identify why people are coming into the hospital and why people are dying, and then you need to realign your services around that. They need to work with the community controlled sector to identify those areas. We need to pick up people with high blood sugar levels, people who are not managing their cholesterol or their blood pressure, those who are smoking or drinking or not exercising. Those are causal factors of chronic disease. What can we do in the primary healthcare space to identify, detect and prevent people from needing to go into the hospital where they are then part of the stats for hospitalisation and mortality?

The biggest thing was changing that mindset and getting them to see that it is part of a longer-term journey and that what we do in health has to also pick up the environment that people live in. I go in to Yarrabah to get my health check. I go in once every three months for an hour to check all my medications and all that with the doctor. For the other part of however many hours there are in that three-month period, I am back in my home environment. How do we get to see the health providers? With what they do here, there is very limited time to get it right; how do we then take that health out into community, into homes, into schools and into aged-care? That is probably the biggest challenge that I see, because if you do that right then you have local-level solutions. You can then pick up around how we improve the workforce in Cairns, Mackay HHS or Townsville. How do we then engage with the schools; how do we then work with the universities like CQU and JCU to actually get kids channelled through; how do we work with TAFE to get the workforce, to get the programs and infrastructure we need.

CHAIR: Cleveland, the federal government's Productivity Commission report into mental health noted the need for local planning and control of mental health services. It seems to me that community controlled organisations have been doing this for a fair while now in a general sense. Is it fair to say that the organisations that your group represents develop strategic health plans for each of the communities? Would taking the same approach to mental health be something that would be beneficial moving forward?

Mr Fagan: You are right on there, Chair. I suppose this is the reason why Haylene and I work closely together. The HHSs have their needs based plan, the PHNs have theirs that they provide to the Commonwealth and the community controlled sector has ours. We need to join that all up and we need to have the one plan. What I spoke to Bevan about is that we need to understand the need at a community level. If we understand the need based on the data and what the community says are issues we can then look at the model of care that we deliver across the whole health system, the role that we play, the role that the HHS plays and that the private GP plays. We can then extrapolate out the workforce we need, the infrastructure we need and the programs we need. Then we look at the amount of health investment going in and determine whether that is being delivered in the right areas and whether the right organisations are getting the money to deliver their parts of that health system and, if not, that is what the health equity is supposed to be about.

CHAIR: Ms Grogan, anything to add?

Ms Grogan: I would probably just do a bit of advocacy for the community controlled sector. In terms of mental health, I do not think they are adequately resourced to deliver mental health services. They are probably the best placed where they are. We do not have Aboriginal and Torres Strait Islander community controlled health organisations everywhere in Queensland. There is a whole window out west where we do not have them placed and we need to get it better in some places. The community controlled sector, which is best placed in terms of local service provision, is not adequately resourced for mental health services.

Where we are in terms of the hospital and health services, and we do have the resources and maybe even the people—I was going to go back to the question from the member for Whitsunday about barriers. We need to have relationships with Aboriginal and Torres Strait Islander communities and be prepared to actually go on a long journey. We say this, but governments have three-year cycles and it is hard to get that commitment to a long journey.

If you go back, Aboriginal and Torres Strait Islander Health really has a good history. If you map back to 1989 when they launched the very first national Aboriginal health strategy, it was co-designed with community and led by our mob. Queensland was the first state to actually have a 1994 Aboriginal and Torres Strait Islander health policy to support that strategy and it is what many of us have come out of. It was designed to have health coordinators.

If you map the improvements that have happened over the years, it has taken almost 40 years to get to the point where we have a chief Aboriginal and Torres Strait Islander health officer, we have executive directors and directors in the HHSs and we have a community controlled sector as strong as it is in Queensland now. It has taken time to get there. That is why we cannot miss the opportunity that we have right now with this change in the legislation. I know we are in an historical moment with COVID, but we are in the most historical moment in time with this chance to get this right. We have to. We have to work with the community.

CHAIR: I would like to thank you all for coming in, giving us a presentation and taking the time to make submissions. It really does help to inform the committee's thinking. We will, with permission from community leaders, be trying to visit some Indigenous communities. That will certainly also very much inform our thinking going forward and will also build on what we have talked about today.

There were some questions taken on notice and we would like the response to those by 18 February. If you want to table the documents you referred to, the secretariat can assist you with photocopying those and we can table them for the benefit of *Hansard*.

Ms Grogan: Thank you. I would love to.

CHAIR: Finally, I would like to thank all of you for the work you have done always but particularly over the last couple of years during the very difficult times of the pandemic. On behalf of the committee please thank all of the people who work in your various organisations for the work that they do. I would now like to close the proceedings. Before I do that I did just want to bring to the attention of committee members that if you would like to put additional questions to any of the witnesses today, could we have those to the secretariat by close of business Monday. That would be greatly appreciated. I now formally close the proceedings. Thank you everybody. Thank you, Hansard, and thank you to the secretariat staff for their support today.

The committee adjourned at 4.14 pm.