# *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

**THURSDAY, 17 FEBRUARY 2022**

**Brisbane**

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**The committee met at 10.48 am.**

**BOSEL, Mr Mike, Chief Executive Officer, Brisbane South Primary Health Network**

**GILLIES, Ms Sandy, Chief Executive Officer, Western Queensland Primary Health Network (via videoconference)**

**KRUYS, Dr Edwin, Representative, Royal Australian College of General Practitioners, Queensland Branch (via videoconference)**

**MARTIN, Mr Paul, Executive Manager, Brisbane North Primary Health Network**

**CHAIR:** I invite each organisation to make a brief opening statement. We will keep it brief because we are only on until 11.30.

**Mr Bosel:** I would like to acknowledge the traditional custodians of the land on which we are meeting today and pay my respects to eldest past, present and emerging.

Thank you for allowing us to be here today. We are here today representing PHNs in Queensland, not any individual organisation, and to answer any questions you may have on our submission or, indeed, any other questions that may arise as a result of appearing here today. It is an important time to look at the mental health system in Queensland—not only because of the increase in demand for mental health support services in our communities but also because the last 18 months have proven that the delivery of health care can, and perhaps should, be done differently. The Australian and Queensland governments have had to adapt quickly to respond to the ever-evolving COVID-19 pandemic, and we have an opportunity to use this momentum to embark on long overdue system reform.

Queensland PHNs acknowledge the significant impact of mental health on communities right across our state. This includes considerable health impacts but also social and economic impacts. The National Health Reform Agreement sets out the role of PHNs and HHSs: to work together at a regional level to plan and co-commission services. While there is very close collaboration and consultation between PHNs and HHSs in Queensland, the full joint regional planning and commissioning of services is still the goal but, unfortunately, not the reality. Queensland's Mental Health Commissioner raised this as one of the key priorities for reform when he appeared before this committee last month, noting that co-commissioning is a more efficient and effective use of the resources we already have.

Queensland PHNs fund around $150 million a year in mental health and suicide prevention services. That is mainly to the not-for-profit NGOs and, in a small amount, private providers. In terms of numbers, this supports 55,000 individuals. It also accounts for over 460,000 occasions of service across the state, including remote and very remote areas such as Western Queensland. Our colleague Sandy, who is joining us via videoconference, will be able to talk more clearly about the challenges we face in those remote and very remote areas.

Our submission talks about the importance of co-designing stepped care that is responsive to local needs. That is something the committee has heard from a number of different stakeholders and I heard it this morning as well. We need to ensure people are assessed and linked to the level of service they actually need, ranging from prevention and early intervention through low, moderate, high and complex needs to that unfortunate crisis response. I know that Professor John Allan has spoken to you about some of the conversations he is having with the Commonwealth on the national agreement and where the state can take up additional responsibility in the early intervention and prevention space. PHNs and their respective HHSs should be undertaking joint needs assessments to identify consumers who are not receiving the appropriate service across the care continuum and to allow for the co-design of stepped care models.

Workforce planning is another key priority, particularly in meeting workforce needs in remote and very remote areas. We need to design joint workforce strategies and commit joint resources to implement these. There must also be a focus on a peer or lived experience workforce and longer

funding contracts for tenure and security. All levels of government need to address inconsistencies in data collection and focus on developing evaluation processes to determine the effectiveness of mental health and suicide prevention services. Data is key, and there should be a common minimum dataset across providers and a greater sharing of data.

Finally, we have highlighted in our submission the need for funding to reflect the requirements of a stepped care model and support joint commissioning efforts. While acknowledging that national agreement negotiations are ongoing, Queensland PHNs urge the state government to consider mapping and tracking all funding directed to mental health services and implement more flexible funding pools. Both the Commonwealth and Queensland governments need to commit to fundamental system reform to improve mental health outcomes for Queenslanders. We as PHNs in Queensland acknowledge that this is a really significant task to take on, but we are encouraged by both governments' efforts to work together and look forward to delivering these reforms for Queenslanders.

**Dr Kruys:** I would like to thank the committee for the opportunity to give evidence. I am an all-round general practitioner working in Maleny. I have been a fellow of the Australian Royal College of General Practitioners since 2008 and I have a special interest in mental health. I have also worked as a GP with a special interest at the mental health unit of the Gympie Hospital, and I have a management role as GP liaison officer at the Sunshine Coast University Hospital. I am appearing today before the committee on behalf of the Queensland faculty of the RACGP.

General practitioners are the first port of call for many patients with mental health issues, but GPs also play a vital role in the ongoing support of people living with mental health conditions. Four out of five GPs report that their patients with mental health conditions have most of their care provided within the general practice setting and 82 per cent of the Medical Benefit Schedule for mental health services is provided by GPs, but primary care needs more support. There is a concerning lack of access to community treatment options for people with mild to moderate mental health conditions. Public mental health services appear overwhelmed and only focus on the severe end of the spectrum. Private psychiatrists and psychologists often have long waitlists, and many patients are unable to afford the private out-of-pocket expense. In certain circumstances, general practice is the only point of care for people who require mental health services, especially for low socio-economic groups, those living in rural and remote areas, and people with dual diagnosis—for example, a mental health condition in combination with substance use for chronic pain.

Rather than addressing problems when they have deteriorated dramatically, there is an opportunity for the Queensland government to better support mental health care at the primary care level before it escalates to the point requiring hospital care. The RACGP believes in the importance of GP access to support and advice from mental health specialists such as psychiatrists, for example, via phone or rapid secure electronic two-way communication methods. Mental health care is teamwork. Effective communication between professionals assists patients to navigate the complicated health system in terms of the quality of their care. This includes timely, succinct hospital discharge communication with treatment recommendations for GPs and patients whereupon mental health professionals, including mental health nurses, peer support workers and carers, should be integrated within general practice. Vice versa, GPs with a special interest in mental health should be given the opportunity to work and upskill in hospital mental health departments. The RACGP offers psychological skills training that provides GPs with the essential skills to provide CBT derived counselling to patients in their practice. It would be beneficial for rural, remote and other Queensland communities if the Queensland government was able to support a similar program to fund or co-fund GPs to upskill and undertake this training.

The Medical Benefits Schedule should accurately capture the time spent caring for individuals with mental health needs. The RACGP continues to present the case for MBS reform to better support the needs of patients, both face to face and via telehealth. E-mental health treatment options often relate to online interventions for the prevention and management of mental health illness. The RACGP supports this as a complementary activity to face-to-face services but not as a substitute for all patients.

The physical health of people living with mental illness requires the integration of mental health and physical health care. General practice does not draw a distinction between mind and body systems. An assessment and treatment of mental illness is informed by a holistic whole-of-person approach. Finally, ongoing relationships between patients and the general practice team can facilitate early intervention for emerging symptoms and the assessment of, for example, suicide risk. Continuity of care in general practice leads to greater patient satisfaction, hospital avoidance and lower mortality

rates. For these reasons, at all levels of the healthcare system patients should be encouraged to find a long-term GP they trust. Thank you again for the opportunity to appear before you. I look forward to answering your questions.

**Dr ROWAN:** Mr Bosel, we heard earlier about co-commissioning and coordination and integration of the provision of these services in Queensland. How can there be better and more integrated collaboration and coordination between PHNs and hospital and health services in Queensland?

**Mr Bosel:** I will give an answer from one side and I will turn to Paul to give another side. From an executive level we are reliant on the personal relationship that exists between the PHN executives and the HHS executives to effectively co-commission in certain areas. I would say co-commissioning or joint project procurement is not the norm. This happens on infrequent basis but it clearly could be more extensive than it is. We are fortunate that Metro South shares the same boundaries as we do as a PHN, as we do with Brisbane North and Gold Coast. Sandy, unfortunately, has I think at least two HHSs up there, if not three. If we go up to the Sunshine Coast and Wide Bay, there are a number up there. We are fortunate in this area of the South-East Queensland quadrant to have one single Metro South. We must mandate joint planning followed by joint commissioning becomes the norm rather than the outlier.

**Mr Martin:** I would add that we have some experience to build on. Every PHN has worked with its HHS to develop a foundational joint regional plan. There are governance structures around that. All of us have a plan and we are all now working on implementing that plan. That is a good thing to build on but that needs to be much more sophisticated. That was the first attempt at doing it a couple of years ago. Now we need to build on that.

We also have the new national agreement between the states and the Commonwealth around who is responsible for what and how things are going to work. What we are missing is something in between at the state level. At the moment each PHN and each HHS is going off and doing its own thing. What does joint regional planning mean? What does co-commissioning mean? How do we all do? We are all doing it differently and separately. What we need is some guidance or agreement at the state level—and we put that in our submission.

We need some kind of a Queensland framework that will say what things need to be delivered at the state level—like telephone services, for example—what things should be consistent across the state but delivered regionally, and what things are able to be delivered at the regional level but look different at the regional level. Once we have that framework and we have some governance guidance around how HHSs and PHNs and other funders can work together around joint regional planning and co-commissioning, then that provides a template for the regional areas to implement and we will have a little bit of consistency in the structure and the process around the state but then content will be different as the PHNs and HHSs and stakeholders work together to roll that out. I think we have some good things to work on but there is a missing part at the state level.

**Dr ROWAN:** To the RACGP and to Dr Kruys, I thank you and your colleagues for all the hard work you do in primary care, particularly with the vaccine rollout over the last two years. Some amazing work has occurred in primary care through general practitioners and their clinics and networks. What are general practitioners seeing and reporting in relation to mental health and alcohol, tobacco and other drug conditions as a result of the COVID-19 pandemic? I know you have alluded to some things around MBS reform and telehealth. Are there additional targeted supports that either state or federal governments can fund given what we have seen to date with COVID-19? The Mental Health Commissioner in a previous submission and in a previous hearing has said that there will be a tail over the next few years as well. What additional targeted supports are going to be needed in the coming months and years ahead?

**Dr Kruys:** That is an excellent question. Indeed, GPs all over the state see an increase in mental health conditions. You are referring to people with different diagnosis or dual diagnosis including substance use disorders. GPs are spending a lot of time at the moment talking to these patients. They are often isolated not because they have COVID but because their mental health is getting worse. It is expected that that will continue for quite some time to come.

If you are asking what is required and also referring back to your previous question, as to legislation, I understand that PHNs and HHSs have a collaborative protocol but implementation varies across the state. What is required is designated funding to assist these collaborations to take place across the state.

When it comes to GPs, I think GPs really need quick access to support and advice from alcohol and drug professionals, from psychiatrists. It does not always mean that a patient has to physically be referred to a hospital or a service. GPs can do a lot in the community with their GP teams and other health professionals, but advice is really important.

In my area, the PHN is funding what is called a GP psychiatry hotline which we can call to get advice from psychiatrists. Interestingly, these psychiatrists are all from New South Wales. I think we really need something uniform here in Queensland with our own mental health practitioners.

Timely communication back to GP is incredibly important if somebody has been discharged. We know that in the first week after discharge suicide rates are increased. We need to better collaborate across primary and secondary services and work better together to support this group of patients as you have just referred to. It can be by incorporating mental health professionals within the general practice team. Also, in Queensland we have an excellent GPSI program—GPs with Special Interests—that do short stints in hospitals to upskill and then take their valuable knowledge back to the community to provide that care in the community. I will leave it at that for now.

**Mr O'ROURKE:** Given that currently GPs are very much time limited services, how could other practitioners—whether they be nurses or counsellors or social workers—be expanded into that primary care area, particularly around the 'missing middle'? We keep hearing about that over and over again. We need to work out how to address that.

**Mr Bosel:** Absolutely. I think the first thing is that it can be done and it should be done. We do have limited GPs and, particularly with COVID and pandemics, they are time poor. I think the process should be established that primary care does not just consist of GPs and allied health professionals. It should be extended to include not only allied health professionals but people with special interests. It should be social workers and, indeed, I suggest people with lived experience, who bring a wealth of experience to this.

This comes down to really extensive regional planning and looking at their health needs. PHNs as a whole every three years do a health needs assessment. We do not do that at a practical level with Metro South but we would value that opportunity to look at the health needs and mental health needs of our communities at that ground roots level and be able to plan accordingly. I certainly agree with you: it should include social workers and lived experience as a minimum.

**CHAIR:** Would there need to be changes around the MBS and funding models for us to be able to do that?

**Mr Bosel:** It is a difficult question but one that I welcome because I think the MBS items is one thing. PHNs work with GP practices to be able to support them in what they do. I think that commissioning at a local level and building that capacity at a local level will have a far more favourable response than trying to tinker around and change MBS items. The voluntary patient registration scheme, which I think is due out on 1 July—it will move to that continuum of, 'You are a patient on our books for a period of time and we are funded to look at you holistically rather than those quick six-minute snapshots'—will help towards achieving that.

**CHAIR:** The current system seems to be triggered by me coming to the doctor with a specific complaint which I then have a very limited time for the doctor to assess and offer initial treatment or referral. That model does not seem to work particularly well for people with even mild mental health issues. Could a change in funding models allow for greater time to be spent with patients or other practitioners to spend more time in a GP-led clinic?

**Dr Kruys:** Again, I think that is an excellent question. I absolutely think there is a need for MBS reform, if only to encourage collaboration. The biggest risk here is: if we are funding more people to provide care there is fragmented care. There needs to be an incentive for community health providers, whether they be GPs or nurses or psychologists, to collaborate and to meet it better. The current MBS, as you are alluding to, is based on quick throughput. Clinicians are rewarded for seeing more patients. We need more time with patients. Also, non-face-to-face time and collaborations with other health professionals are extremely important in mental health provision.

**Mr Bosel:** That is another excellent question. Within Brisbane South I have 1,389 GPs for a population of 1.2 million. Yes, there needs to be reform in how GPs can spend their time at that holistic approach rather than that six-minute segment. More importantly, even if we were able to achieve that, the 1,389 GPs would not be able to deal with this growing problem. Communities are feeding back to us that we have not even reached the peak of mental health problems and in some cases are talking about the next five to 10 years.

We have to look at areas outside of GPs and commissioning jointly with our HHS early intervention. That may be social prescribing, referral networks, peer work groups et cetera that will actually allow someone to be within the system but not having to go to that GP in the first instance. Everything that we do has to stop someone who has mental health issues using the first point of contact being the emergency department. We should have that stepped model of care which starts at that very social stage and then moves through the various continuums.

**CHAIR:** I want to put a question to Ms Gillies, given her area of operation. In terms of co-commissioning in a remote community or as distinctly remote Indigenous communities, would we have to take a different approach rather than just commissioning at the HHS and PHN level?

**Ms Gillies:** We do have to take into consideration the fact that we have a key player in there—that is, the Aboriginal community controlled sector—who receive funding directly through their funding agreements at a federal level but are also commissioned in my region by us, the Western Queensland PHN. The ability to invest in these joint regional plans is where we will see a commitment by all levels—state and federal and local health service providers—in relation to being able to execute some of these strategies. Otherwise they always just continue to be great ideas on paper. They need to be invested in and they need to be funded jointly by all parties.

**Ms CAMM:** My question is to all three PHN representatives. In the co-design or co-commissioning or even just in your experience of collaborating with your HHSs, do you feel that there is empowerment when you have engaged with the HHS, noting different geographical locations and stakeholders? In your experience, do you think there are any barriers or challenges, whether that be in decision-making or limitations in resourcing et cetera, which if removed would further empower or create a more collaborative model of delivery?

**Mr Martin:** That is kind of what I was getting at in my previous response—that is, around having some kind of Queensland framework for how joint regional planning and co-commissioning happens so that there is a base level of empowerment for HHSs and PHNs around how to do that. At the moment each HHS has had to find its way in terms of what it thinks joint regional planning means and what co-commissioning might mean. If we had a standard framework then a lot of decision-making would be taken out of the personalities and it would be more consistent across the HHSs across the state. Having that kind of state governance framework that has been agreed by the various parties is important.

When I spoke before about other stakeholders, that includes Aboriginal medical services, the Department of Veterans' Affairs and the Department of Social Services. We might even in future get into private insurers. They are a significant funder as well. We need all the funders around the table working together to make effective use of the money that we have.

The other challenge in joint regional planning to date has been that the HHSs have received no funding to do that. PHNs get a bit of funding from the Commonwealth to do that as part of our operational funds but the HHSs do not get anything. They had to scrape together a couple of hours from someone's position to go out and work with the PHNs. Some were able to find more than others. They need to be resourced to be at the table as equal partners. They have much more money than we have overall but they have much less staffing capacity to engage in this type of true co-design regional planning. That is needed as well.

**Mr Bosel:** You already have the structure in place with your commissioner. You have Queensland Health overseeing the hospital and health service. It should not be that difficult to mandate.

**Ms KING:** My question is to the PHNs. It is nice to see you again. You will recognise these questions from our previous inquiry. When we are talking about a genuine co-commissioning model, can you please outline for the committee's benefit what the budget of your PHN is in broad terms and how much of that you have as discretionary funding available for co-commissioning? Perhaps you might like to reflect on what you would need to genuinely engage in a co-commissioning model in terms of funding.

**Mr Bosel:** It is a good question and one I was anticipating. I will talk about the Brisbane South PHN and my colleagues will confirm for their side. Of the $45 million we get, just under $30 million is spent on what we call mental health, alcohol and other drugs. A significant part of what we receive from the Commonwealth is invested in mental health and mental health services. A large chunk of that is in established programs like headspace which will go on year to year. What we do commission we do not commission for the next six months or the next 12 months; we look to commission for a period of time extended beyond that. A successful PHN will have understood the needs of its community for the next three years and will commission accordingly.

My counter to the question around how much discretionary money we have is that a good PHN listening to its consumer needs and health needs will not have the need for that much flexible funding, although we do have within our funding stream a proportion that we can use flexibly in those areas that we see there is a need. That will differ from PHN to PHN.

I would say that we could always do with more money in innovation. The problem with `always' is the difficulty of creating an expectation that there is a solution and then finding in a year's time that the funding stream you had set up for innovation is no longer there. Last week I mentioned our child development program—our TOTs program. That was funded out of a Commonwealth initiative that was there to identify gaps in the system. We did that. Here we are two or three years later saying, 'That funding is now under threat because the funding stream is no longer available for that.' We have to walk this tightrope of creating expectation and responding to consumer needs.

**Ms KING:** In the context of increasing year-on-year demands for mental health, increasing year-on-year gaps identified in primary health care for your communities, is it perhaps the case that what you need is top-ups of that innovation funding on a recurring basis so that you can look into new spaces?

**Mr Martin:** Ideally what we want to get to is a weighted population funding model, where we have the National Mental Health Service Planning Framework that looks at our local population, tells us the range of services that they need and can come up with a dollar amount. What would it cost to respond to all of the mental health needs within the region? That is what we have to get as close as possible to—for that to come as an unrestricted pot of money to the regional areas for those services that are delivered regionally and through our joint regional planning to then decide how best to use that pot of money.

At the moment what comes to PHNs is seven or eight different streams of mental health money. Each of those streams has a notional budget that the Commonwealth comes up with. We change that with their approval, but they say, `We would like you to spend this money on this, but if you want to spend something different then come back to us.' Each of those streams has its own guidance that we need to respond to. If we want to do something outside of those streams, there is not any money to do that.

Those streams are decided nationally. When PHNs got some additional money to respond to the mental health needs of people with COVID, we were told how to spend it: `Here is some money for working with older people.' There is nothing wrong with that, but perhaps we could have been given a pot of money for the key mental health needs in our regions and PHNs and stakeholders could have decided how to use that. That is not how it worked. The department federally decided what that money was to be used for and the PHNs just had to implement that. Some greater flexibility by all of the partners with a notional or virtual single pot or pool of money that we can use to put into services where they are needed is the most ideal situation, but we are not there at the moment.

**Ms KING:** What I am hearing is that you have structural challenges that prevent full engagement in joint regional planning at its most effective?

**Mr Bosel:** I would be a little bit nervous about confirming that, but what I would say is that understanding how much more funding we need and the structure of that funding is probably the question I would ask, after we have joined up with our HHSs to effectively co-commission at a local level. I have no idea what impact the joint pool funding will have and whether in fact we could be overfunded. Typically in duplication there is often an increase over what it effectively should cost. I would strongly recommend that we approach that at joint regional planning and then joint co-commissioning and then decide whether there is a sufficient pot or that pot needs to be increased.

**Mr KATTER:** My question is probably to Sandy because my primary interest is in the remote areas and perhaps regional areas as well. I understand that this has in part been answered, but I am not sure I am across the answer to this issue. For example, in the gulf a number of service providers will go up to Normanton and Croydon. I will pick on speech therapists or OTs. One from the HHS, one from Bushkids and one from the primary health network goes up there. I lose track and get confused. I ring up and ask who is doing what. It is difficult to know who is coordinating all this when we have a critical mass. We can apply that to mental health.

Not going all the way up to federal and state health ministers but back down the hierarchy a bit, who oversees and coordinates things and says, 'We have only one going out there now from these three bodies. We have one psychologist.'? Do they talk to their MPs or HHSs? I not sure how all that works. I think it applies to mental health supports in remote areas.

**Ms Gillies:** The Western Queensland PHN gets $6.1 million to cover 55 per cent of the state. There are 62,369 people in our footprint. We use the intelligence that we have around our practice data and the health needs assessments to determine where the funding needs to go across that stepped care model. The point that Paul raised is that at that local level when you are starting to coordinate those services neither party—for example, the HHS—is accountable to the other. They can go in and say, 'We have a private psychiatrist. We are going to put them on a plane and run them across that lower gulf region.' Then two days later we might be taking in a social worker. That individual is seeing two different people over three different days having probably travelled a thousand kilometres both times just to get into Normanton or wherever to access those services.

The need for joint planning and commissioning is critical to avoid those inefficiencies but also to have clients in a wraparound service where they are supported across the whole journey as opposed to this ad hoc response. Care is not connected up because nobody shares data, especially in mental health. There is a big issue around patient confidentiality. Nobody is prepared to do any of that shared care planning or shared workforce solutions.

**Mr KATTER:** That is brilliant answer that ground truths well with what I see on the ground. What is the answer then?

**Ms Gillies:** I think the answer is these joint plans where everyone puts their money on the table and through our local health intelligence and community intelligence work it out. That is important. We have seen it in the floods. Western Queensland PHN covers 20 LGAs. Over the past nine years every LGA in the Western Queensland patch has been drought-declared. In 2019 five of our LGAs were affected by the devastating monsoons. We went to people and said, 'What do you want?' We did not have one suicide as a result of our efforts. That is about increasing community literacy and getting them to be comfortable about seeking help so that they are not presenting to an emergency department. That costs money. Keeping them connected with their community costs money. Then we can determine what services we want. We then commit together as the HHS, PHN and any other providers. The member for Traeger knows better than most the effect mental health, suicide and AOD are having on our young people in our region. We need the department of communities and other government departments to have a whole-of-government approach to this because the demands are outstripping what we can provide with $6 million.

**CHAIR:** In relation to the data notion that keeps coming through from several people, has electronic medical record assisted in relation to that particular matter?

**Dr Kruys:** That is a good question. I would need to take that on notice. My personal experience is that it is fairly limited. What the previous speakers have outlined is the risk of fragmentation here. There is a lot of fragmentation here. Whatever funding we are going to consider, we need to make sure that that does not happen. If you have been a GP for 10 or 20 years, there is a lot of stop-start funding and a lot of different initiatives, and patients—and also often GPs—cannot keep track of all of the different initiatives. We need incentives that support collaboration between professions.

**Mr Bosel:** Data is very powerful. We have some systems in place like the PIP QI, which was introduced by the Commonwealth recently. I have the pleasure of sitting on the steering group for My Health for Life which is an initiative funded by the Queensland government. When we looked at how we can target the program we used our PIP QI datasets and we were able to see just in the Brisbane South area with 247,000 potential patients who had gone through our GP practices at least three times in two years who would be appropriate for that program—not just in terms of patient numbers but by their location and GP they were attending. That is a powerful dataset that we should be using across multiple platforms.

The other thing I would say is that, sadly, we still use something in Brisbane South called the yellow envelope. When someone comes in from residential aged-care into a hospital, they have a yellow envelope which has all their details. That stays with them. They go into the hospital and what is supposed to happen is that the details coming out of the hospital go back into this yellow envelope. There are probably hundreds of thousands of yellow envelopes somewhere in the system because they are not coming back. Despite how far technology has grown, we are still reliant on something that is paper and yellow.

**Mr Martin:** I think My Health Record is being used mainly as equivalent to a file storage system. Stuff gets uploaded and then sometimes a practitioner might look to see what has been uploaded but it is not an active care plan. It is not an active care plan that clinicians can write to, and it is certainly not an active care plan that consumers can write to and actually own. Whether it is through My Health Record or through some other system, we need an active, alive care plan that can keep up to date with what people are doing and can determine what is going to happen for a person, not be a kind of historical record and file storage. We need it to be dynamic.

**CHAIR:** On that point we will have to bring this section of the hearing to a close. We have had a couple of questions taken on notice. I would ask for the answers to those be given to the secretariat by 25 February. I do want to thank you all for your attendance here today and thank all your members for all the work they have done over the last couple of years in what would be described as very trying circumstances for health professionals and health workers. Members of the committee may inevitably have more questions for you and we will put those to you via the secretariat after today's session. Thank you very much. This has been very useful.

**MANOHARAN, Dr Bavoharan, Vice President, Australian Medical Association Queensland (via videoconference)**

**PERRY, Dr Chris OAM, President, Australian Medical Association Queensland (via videoconference)**

**CHAIR:** Welcome. I invite one of you to make a brief opening statement before the committee starts to ask some questions.

**Dr Perry:** Thank you very much to the members of the committee. Thank you for the opportunity for AMA Queensland to present to this inquiry into opportunities to improve mental health for Queenslanders. We support the Palaszczuk government in establishing this inquiry on the basis that AMA Queensland has seen mental health services deteriorate badly in the last decade under the watch of successive state governments, both Labor and LNP, to the point where the Queensland government spends the lowest amount on mental health per head of population of all the Australian states and territories, which is a problem.

AMA Queensland believes current investment of an extra $700 million per year is needed to address the unmet need in Queensland. This level of investment is more important than ever due to the impact of the pandemic on the mental health of millions of Queenslanders. This level of funding would be consistent with the $850 million per year on a pro rata basis that the Victorian government committed following its royal commission into Victoria's mental health services—so on the same sort of page as Victoria per head of population.

The gaps in mental health services are many. There are gaps across the entire spectrum of mental health, including perinatal mental health, children and adolescent mental health, which is a real problem—we can go through that later—and older people including those presenting with a dual diagnosis of mental health linked with other health co-morbidities and substance abuse, which is getting much more common in our community. These gaps have led to major increases in people presenting to their GP for care, with our members reporting increases of between 30 per cent and 50 per cent in patients presenting with mental health conditions since the pandemic began—this is to GPs. We know that 75 per cent of the population approach a GP in the first instance for care of their mental health condition. People go to their GP first. They are still an important part of the whole healthcare system. Of these people who see a GP, six in 10 are prescribed medication, three in 10 receive some counselling and sometimes that counselling—

**Dr Manoharan:** It looks like we have a problem with the video connection. If you can hear me, I might pick up where Chris left off. As Chris was saying, we know that 75 per cent of our population first approach GPs for their mental health condition and, of these people who see a GP, six in 10 are prescribed medication, 30 per cent receive some counselling, education or advice, and only two in 10, so 20 per cent, tend to receive a referral to a psychologist or a psychiatrist. The long waiting list to see a psychiatrist and public or private psychologist in Queensland of between six months and two years really does leave many patients with limited options to receiving specialist care. It is the GPs who are then caring for those patients for longer.

We know that 28 per cent more patients have presented to emergency departments with mental health conditions since the pandemic started. That is an increase of over 70 per cent in the last five years. People with mental health conditions presenting to emergency departments can have their treatment assessment delayed due to access blocks which can exacerbate the distress of a patient in the emergency department—with associated side effects on other patients, hospital staff and carers, including a heightened risk of occupational violence—and add to the overcrowding and access block in emergency departments. This is why we have been asking for more beds to be allocated to emergency departments for patients presenting with mental health conditions. Another major gap is the missing middle—that is, people who have symptoms that are too complex to be adequately treated by a GP but whose condition does not reach the threshold for access to state or territory funded specialised mental health services.

There are major changes that we think are needed to the way that mental health is addressed in Queensland, and I will cover off on some of these actions. Action 1: establish a new governance system. At present there is a lack of accountability and sufficient monitoring of resources and resource allocation and utilisation. We recommend this role be transferred to the Mental Health Commissioner as the current system is clearly not functional or transparent.

Action 2: review the way mental health is funded, review the way that GPs are subsidised to support mental health and extend activity based funding to community ambulatory mental health services. This would reduce incentives for local hospital networks to prioritise hospital based care,

which may lead to a reduction in the number of people with mental health illnesses being held in long-term hospital beds. The last point there is to increase funding for community mental health services.

Action 3: address the gap in the mental health workforce. The deficiencies in workforce and core funding are a main cause for primary care overload, emergency department ramping and the rest of essential services like housing, education and social services. There is an incredibly strong demand for mental health services, including private mental health services provided at a cost to consumers, and we have seen demand outstrip supply even in the private sector. We need to invest in the training pipeline for GPs, in budding psychiatrists, psychologists and other potential mental healthcare providers into this sector—more importantly, into our regional centres. As long as there is statewide demand for services, rural, remote and regional centres areas will continue to struggle to attract and retain a mental health workforce as city based demand attracts providers with better remuneration and lifestyle considerations. To solve the rural workforce shortage, it needs to be done in tandem with a workforce audit solution for the state, not in isolation. We need strategies and funding in place to improve and protect the psychological wellbeing of our workforce. The burnout rate for medical and other healthcare practitioners has increased significantly in the last two years of the pandemic and we are anticipating significant numbers of practitioners to leave the profession—and we have already started seeing that—over the next few years as a result.

Action 4: provide more beds in emergency departments to people presenting with mental health conditions. With 28 per cent more patients having presented to emergency departments with a mental health condition since the start of the pandemic, it is prudent that the Queensland government address this as a matter of urgency.

Action 5: establish multifunctional service delivery centres to provide care for people with multiple or dual diagnoses. Mental health services should be required to ensure treatment is provided to both mental health illness and substance use disorders for people with both conditions.

Action 6: support increased use of technology. AMA Queensland considers that technology is the primary means to overcome the gaps in access to mental health care in rural, regional and remote parts of Australia and are the result of workforce shortages. Encouraging the increase of telehealth and clinician supported online treatment options is one primary way to address that.

Action 7: supporting additional mental health training and professional development for GPs. Because 75 per cent of the population access a GP in the first instance, as Chris pointed out earlier, we ask the Queensland government to support additional mental health training and professional development for GPs, including approaches into assessing mental health and additional training on medication management and deprescribing, including online supports. Finally, we ask that the Queensland government maintain a focus on addressing the occupational violence which remains a major issue for staff in emergency departments, in psychiatry inpatient units, as well as in our community settings. Thank you.

**CHAIR:** Thank you, Dr Manoharan. Thank you for an excellent presentation of the issues and the concerns from the perspective of the AMA. I think if we take it as a given that mental health funding at the state level is not where it should be, it would seem to me that if we focused on funding the aspects of the mental health service that the state government is currently responsible for we would end up with much bigger mental health hospitals, possibly better GP services and some improvements around ambulance services but we would not necessarily end up with that sort of early intervention and that missing middle that you are talking about there. If the state government was to try to reach into that missing middle, what would be your suggestion around the priorities? Is it these multifunctional care services that you talk about or is it about trying to work more collaboratively with GP services?

**Dr Perry:** I think it is a bit of both. AMA Queensland and AMA Australia have been trying to not sheet the blame home to anybody, but for the last 40 years both levels of government throughout Australia have underfunded health. We seem to be proud of nine per cent of GDP as our costs, but it is coming home to roost. We have been too close to the bone for too long and good services are being cut out. GPs are not being paid enough to have appropriate time to see people coming in and they are seeing 75 per cent of people, and it can be four to six months to see an adolescent psychiatrist if your teenage son or daughter is threatening to harm themselves. It is just outrageous. A number of these things could be helped by GPs, but they need the funding to cover their rates and the wages of their staff. For an hour or so to be paid $39, bulk-billing out of a metropolitan area, a rural area, is just silly. There needs to be better funding of GPs.

Satellite hospitals are called hospitals even though there are no doctors, which is a bit of a bizarre thing. They are a perfect opportunity. I think they are going to be half white elephants. They are a great thing to have some chairs for intravenous chemotherapy and for dialysis. It is nice to have people with those chronic conditions not having to travel into a big hospital. There are no doctors there and I think therefore a lot of those people who need dialysis and chemotherapy will not be suitable to be away from local medical care. We might find there is a lot of extra room there and that will be a great place to have community psychiatry.

**Dr Manoharan:** My only addition to that response from Chris is that we really need for that missing middle to look at early front-loading of specialist care. Early in the process we need a mechanism for GPs to be able to get that specialist care and that care can then be broken down to be provided in a community setting by GPs but under a global governance system by a specialist. That is probably what we need. It is the care coordination more than anything else. Currently, there is no mechanism for that and there are also no funding models associated with that.

**Dr Perry:** It is GPs and shared care between multiple different levels. The nurses are very important. Social workers, psychologists as well as psychiatrists and regular doctors are a part of a team for mental health.

**CHAIR:** You noted in your submission and in your presentation today that the outcome of 60 per cent of GP visits is use of medication as a first line of treatment. I am certainly not opposed to using medications as a nurse. Do you believe that if we had a different model of funding, particularly the care of people with mental health or AOD issues, there might be more treatment options available for GPs rather than just the quick, easy medication script?

**Dr Manoharan:** When we talk about those 60 per cent who are prescribed a medication, that is generally in consultation with their GPs over a period of time; it would not be a first-line treatment and it certainly would not be the only treatment option. We know from evidence that medication only works in tandem with other therapies. Cognitive behaviour therapy is one of those therapies. Part of the issue is the training that a single health practitioner has to cover the gamut of those therapies. A GP might understand the pharmacology and the pharmaceutical aspects and know to refer them on to a psychologist for the CBT, but if they cannot access that psychologist to get that CBT, if the GP cannot provide it themselves, they are left with the medication, which can be an issue. Part of it is training. Part of it is making sure that we have more broadly trained mental health professionals who have the ability to deliver all levels of that first entry level care.

**Dr ROWAN:** In AMA Queensland's submission, you have asked for the extension of activity based funding to community, ambulatory and mental health services. Can you elaborate further on that? Should that same model of activity based funding also be applied to public alcohol, tobacco and other drugs services and to the alcohol and drugs sector more broadly?

**Dr Perry:** Bav is very much involved with medical administration and knows more about this than I do in many ways. It is 40 years since I have really been involved with psychiatry, but I do come across a lot of people who (inaudible) their treatment and I get them onto a psychiatrist as quickly as I can. I think activity funding is a pretty good idea, especially in a public hospital system, because sometimes our processes are so complicated and arcane that people get caught up. It is quite hard to get (inaudible) public hospital operating theatre list. You can do four cases in a public list and you can do 12 in the same time in a private list. Once people get into a public hospital system for any service at the moment, they get Rolls Royce treatment, which is what you want. We have quite a hostile regulatory environment, both within the hospital and outside, with lawyers, the Health Ombudsman and Ahpra. Everything is done really well, but the problem is getting in in the first place. I would like to see more GPs involved. When I was doing psychiatry 30 years ago, there were two drugs. There are now that many you could (inaudible) let alone schizophrenia or the role for electroconvulsive therapy, which still has significant roles in severe mental illness.

**Dr ROWAN:** Dr Manoharan, we have been hearing through this inquiry that workforce challenges are significant. Would the AMA support a Queensland Health dedicated and funded statewide addiction medicine registrar training program? If so, how could the AMA assist Queensland Health in establishing that in collaboration with the relevant colleges, that being the Royal Australasian College of Physicians and the Royal Australian and New Zealand College of Psychiatrists?

**Dr Manoharan:** It is a very clear answer. The answer to that is yes. We do need to co-invest. In our submission we did talk about it often being difficult to separate out those diagnoses of mental illness as well as substance abuse disorder. Co-investment and co-design of pathways for both those diagnoses is important but, certainly from a training perspective, we really do need to increase that

funding pipeline. There is an overlap between mental health and addiction; however, they are distinct medical specialities. The only way we start a training pipeline is if we invest in that. Part of that will be around looking at where we can attract talent from. If that is GPs who have an interest in mental health then it is about establishing a training pathway for GPs, especially if they are the ones in our regional and remote settings providing these services.

There is a lot more consideration that needs to go into workforce. It is not as simple as setting up a pipeline. For example in psychiatry, there are psychiatry registrar positions vacant in inner-city Brisbane. If there are vacancies there, you can only expect and anticipate what level of difficulty there is in a regional setting in attracting those to work in regional settings when all of their training has been in an inner-city environment. Beyond just setting up the funding, the pathways and the college and accreditation processes—and we are absolutely happy to assist with that—it is going to be around looking at those pathways to drive people to work in areas of need. Telemedicine and video medicine only help to a certain degree. We do need presences there, and we need to upskill our regular practitioners in those areas.

**Ms KING:** Thank you for your detailed submission. I want to touch on this issue of workforce, in particular the issue of regional workforces. While I note your comments about the importance of telemedicine and video medicine to deliver mental health services into rural and regional communities—and I know some of my rural and regional colleagues will doubtless have some questions to ask about this as well—what I have heard in this and other inquiries I have been involved in is that those services only go so far and that people certainly want that face-to-face interaction as well, perhaps at intake, and then thereafter telemedicine is more appropriate. In terms of ensuring that we can build and grow a good regional workforce for mental health, the deputy chair and I have heard in our other inquiry quite a lot of submissions from JCU about its 'grow your own' approach—the idea that you find people in rural and regional communities, train them in those communities and, ideally, place them in those communities. I would love your comments on that. How can it be better supported? In particular, are there enough Commonwealth supported places in those regional settings to help us grow our own regional mental health workforce for the future?

**Dr Perry:** It is a problem all through Australia, with every speciality including general practice—getting people to go to rural areas where the lifestyle may not be what they are used to. Their partner maybe has a job in South-East Queensland because they went to university maybe in South-East Queensland. I know that JCU has a very good program to try and encourage people to stay in the country, but only a proportion, less than 50 per cent, actually do it. We are trying to get local doctors and the hospitals to engage with the local councils in the big towns to try to encourage the young doctors who go there to realise that lifestyle is good there. We also should take note of the fact that it can be quite expensive. Two of my colleagues left a large country town when they realised they could not afford to get milk on the table because they had two or three kids at boarding school at the same time. It can be quite difficult to be a GP in the country and get your kids educated.

**Dr Manoharan:** There are certainly lifestyle factors as well as other factors in it from a social setting. There is the professional development aspect as well. That is something that we have been grappling with pre-pandemic—and the pandemic just really brought that home—where in terms of professional networks some of these practitioners do not feel fully equipped and do not get the peer support that they would if they were based in a more densely populated area. Even if they are a solo practitioner in a GP practice, they still have access to proximal support services. In terms of a training pipeline, we have seen some good initiatives happening in Central Queensland with their end-to-end medical program. It is a partnership model, really, between multiple universities which traditionally did not offer medical services education. We are seeing some of that happen in the Darling Downs as well to establish that. That is one part of the problem; that is the first part of it.

We need to get local students and high school students interested in health care to the point where they start to enter into this profession. On the other end, once they get their medical degrees we want them to have access to train as much as possible in those areas. At the moment you can certainly do a part of your training in a lot of regional areas, but you still need to attend a population centre, whether it be Townsville, Cairns, Brisbane or one of the coasts, to get the majority of your training. There have been models of training looked at where you actually base all trainees, not just those from regional areas, into regional settings and rotate them through the city. That has been done in surgery in Victoria and is certainly something we could look at. It is certainly something we should be looking at in Queensland specifically, with our tyranny of distance and our mainly decentralised population once you leave the south-east corner. There is good evidence to suggest that if you can get people from those areas and keep them in those areas long enough they develop roots and social networks and will stay there. That is one part of it.

The other aspect that we need to look at when talking about 75 per cent of first presentations going to GPs and primarily GPs providing mental healthcare services in our community is that we need to really attract GPs into some of these areas. GPs are not just there to do mental health; they are there to do a variety of other things and they like that case mix, which is why they pursued the profession of GP. There are certainly some things that are occurring that would disincentivise GPs from practising in some areas. If you talk to some of the senior GPs around regional Queensland they will tell you about their struggles to find junior GPs to come in and take over from their practices or assist them so they can start to retire. The pipeline in replacing our rural workforce broadly, in a general sense, is not there. It goes beyond mental health, which I know is the remit of today's discussion, but you have to consider those as well if we are talking about the rural and regional workforce shortages.

**Mr KATTER:** I might be a little bit vague on the details here, but I recall talking to a GP in Cloncurry post the floods. It was when we had some funding for services around mental health. We had identified that it would be very difficult to capture people. This was in the context of a lot of people on stations that are remote and they do not talk to people. The discussion led to how the GP will often see the signs. The GP I was discussing this with said that there were some clear barriers for them to be able to link with those services. I think that was around privacy. I am sorry to be vague, but I cannot remember what the precise barrier was. Do you know what I am talking about there? Do you have any suggestions around how that could be improved?

**Dr Perry:** I can somewhat answer that. There was a bit of a kerfuffle in the media—AMA federal—about new laws on privacy being introduced by the federal government which will do exactly what you are talking about. Kids Helpline were involved in discussions, saying, `This is crazy. We will not be able to share information.' I am an ENT surgeon. One day about eight years ago I was in Cherbourg at a meeting with Hearing Australia, which provides the hearing aids, the school which looks after the kids who are deaf, the hospital and the local health centre within the Cherbourg community and Deadly Ears. We could not share an audiogram between the five or six organisations due to privacy rules—just crazy. If you have somebody who has significant mental health issues—there may be sexual or drug abuse or domestic violence—the privacy laws can stop appropriate dissemination of clinically relevant information. Yes, it is a problem.

**Dr ROWAN:** I want to come back to the medical workforce, specifically with respect to visiting medical officers. If we have a psychiatrist who moves to Rockhampton, Townsville or Cairns and sets up a practice, what is the process for engaging those people in the public sector if they are willing to provide services to support the local HHS—whether that be psychiatrists or addiction medicine specialists or even rural generalists who might have an advanced credential scope of practice in mental health? Are there any recommendations or advice or thoughts that have been given to a reinvigorated process of engaging visiting medical officers? We are talking about mental health and the alcohol, tobacco and other drugs sector, but equally that is applicable across Queensland in many other specialists as well when we are talking about the workforce in rural and regional Queensland.

**Dr Manoharan:** There are a number of methodologies you can use. VMOs have traditionally been used to engage specialist services into the public sector where partial appointments might have failed. They do come at a premium but they have been effective. I guess it is local solutions for local problems. They do not always work and we do know that as technology has improved there are other mechanisms of engaging specialty services. You might have an advanced credential GP located in an area and as they need specialist advice or dual consultation with a specialist in Brisbane, Cairns or Townsville they can be present on video link. You do have those models. Yes they are costly, but they do afford a stopgap or at least a short-term measure to get those specialist services into an area. Certainly, VMOs is a tried and tested model of engagement. It is already there and useable, but if it is not being used then I guess we need to identify why it is not being used in certain areas. There must be barriers that we need to look at.

**Ms CAMM:** My question is around the mental health and wellbeing of your members, in particular GPs, with the impacts of COVID-19, the pressure on your members and the change in working environments. Are you able to talk to some of those impacts? How is the AMA supporting that or what may be required? As you say, in rural and regional areas we may only have one sole GP or limited GP services. If we lose one of those people, it has an enormous ripple effect on the community. How are your members faring over the last two years? Can you speak to those supports or the lack of?

**Dr Perry:** The AMA tries to address this. The state government tries to with doctors in training. Often when a doctor leaves the public hospitals they are out there by themselves. The AMA does have a program, largely headed by Margaret Kay, to try to get doctors to phone in and talk about their

problems. COVID has been very difficult. There is an awful lot of abuse out there against doctors. There is violence. Doctors are concerned about the change to QScript in terms of telling drug addicted people they cannot get scripts (inaudible) the time is up on it. There is violence within the practices.

There is also the heavy hand of the medico-legal fraternity and, as I said before, the Office of the Health Ombudsman. I know of one addiction specialist who came home after three weeks away to find there were seven complaints to the ombudsman about why he took holidays and was not around to give them the drugs that they wanted, that the locum doctor did not give enough support—he was different—and `how dare that doctor take holidays?' I thought it was a bit strange, but every one of these complaints from the OHO take a good 24 hours or so to respond to. Similarly, a young lady addiction medicine specialist at Ipswich came home from holidays and had two complaints against her for 'how dare she take holidays?'

Sometimes we need some common sense and we need some support. We try and give it. It is a problem. Self-harm and depression is present in the community. There is a block to Queensland doctors going to get support because there is mandatory reporting of doctors who may be thought to be not up to scratch or who may have mental health issues or substance abuse issues so they do not get the help they require.

**Dr Manoharan:** The short answer is that it has had a tremendous impact. It has had a devastating impact. GPs specifically, as members of the Queensland public, have had to go through the rule changes and cater to the needs of their families but then in their practices continue to deliver services to their patients through the pandemic. These are not issues specific to the state or the state government; these are also Commonwealth issues—issues around changing rules for PPE and the COVID vaccination program. There have been a number of rule changes and clinical guideline changes that GPs have to pivot to. There is subsequent abuse from consumers, because the Commonwealth announce something on Friday and people show up on Saturday expecting that everyone in the practice knows about it.

They have had to deal with a lot. What they have probably had to deal with mostly is consumers who are acutely aware of their healthcare needs and being quite demanding. Increasing health literacy and people's awareness of their own health is not necessarily a bad thing, but GPs have had to deal with abuse. Because they are not tied into a system—they are not employees of the state; they do not have necessarily have access to all of the support services we offer to Queensland Health employees— they have been left out a little bit in terms of support. While there are a lot of support services that we offer as a profession—the doctors health program, which Chris referenced, is one of them—and there are a lot of other support networks being set up through the AMA as well as through the colleges, that does not amount to the broader level support that we need to be providing them.

Most GPs would report income losses in the realm of 20 per cent to 50 per cent through the pandemic because of the change in funding models and the ability to deliver services whilst their costs have remained identical. They have still been paying their staff; they still have to maintain their leases. They are small business owners. I think financial distress has also had an impact. We are certainly hearing reports of GPs who are looking for career alternatives, whether they retrain to enter into another speciality or whether they leave the profession entirely. That is really disturbing to hear and quite saddening. We have people with years of experience who can deliver services to their communities who are thinking about leaving it. I think that is what we need to work on now. We need to look at what we need to do to support not just government employees but all health workers—psychologists, psychiatrists, GPs and everyone in between. Unless we can keep them in the sector, we are going to have pressure being put on the state service.

**Dr ROWAN:** Professor Perry, you mentioned the QScript system, the real-time electronic prescription monitoring system that has been implemented in Queensland in relation to Schedule 8 medications and other specified drugs. It is my understanding that the monitored medicines unit within Queensland Health has been downgraded or abandoned—that is, the specialist advisers within that unit. We have had testimony that data collection is very important in relation to not only prescription medications but also illicit drugs. Is there any feedback you could provide in relation to your broader membership and issues they may or may not be identifying in relation to the monitored medicines unit or the implementation of QScript?

**Dr Perry:** There was a fair bit of feedback. Initially, there was some worry about it. When it was brought in, people did not realise it might take a year or more before there may be some penalty for doctors not doing it. You can do it fairly quickly. It is just one more unpaid 'something to do' which is fairly prescriptive and bureaucratic. There does not seem to be any impost on the doctors directly to cut down on how much they are giving to people, but that will obviously come. Is it an issue? I do not know. We will see what happens. Is there an issue not having a people to be at the monitoring unit? I have not heard that, so I cannot comment. Do you know, Bav?

**Dr Manoharan:** I have not heard of that issue specifically, but you would expect that any implementation such as this does have a support behind it. If that support system is not doing the monitoring of the implementation, that is an issue. It is certainly not an issue that is come to the fore at this stage.

**Mrs McMAHON:** I want to focus on some issues that a lot of Queensland parents and families might be concerned about in this space. Earlier we heard that 75 per cent of the presenting population are presenting to a GP in relation to mental illness in the first instance. We have heard the statistics that six out of 10 are getting a prescription but only three out of 10 are getting some counselling. Given the long waitlist particularly in youth mental health, a parent might, quite rightly, send their child to their local GP as a first port of call. We also heard a couple of weeks ago in relation to our suicide statistics that a significant percentage of those who took their life had actually seen a GP in the weeks leading up to that. I want to know as a parent: is that GP visit going to be effective? What do we need to do in our time with our GPs to make sure that is an effective and a quality interaction that is going to have positive outcomes for our children?

**Dr Manoharan:** It will be important to look at the statistics in their entirety. It would be interesting to compare the statistics from a service that does not have a crisis centre or crisis availability of GPs with the statistics from a centre that does. Yes, we know that suicide and wanting to end one's life because of mental illness is multimodal and there are a lot of factors that go into it. You might walk away from a GP, psychologist or psychiatrist appointment and feel a little bit better for a while but then return to your previous way of thinking. It is always going to be different for everyone. It is going to be difficult to predict. I would be interested to know if the numbers would be higher if we did not have those services.

Crisis centres are often underfunded and cannot provide the level of service that they would like to. Beyondblue is a good example of a service that a lot of consumers use but, again, there is a limit to what you can provide on the phone. Referral services to acute settings where you can get in and see someone will be important. If there is an access block, that is an issue. You can pick up the phone and talk to someone, but then we are talking about those per cent of people that need an extra level of care. It is difficult. We need a holistic funding approach to fund those services that are outside of government but also more in the not-for-profit sector.

**Dr Perry:** GPs cannot do much in the short period of the time that is funded. One of the problems is: if your teenage daughter or son is threatening suicide and you want to get them to see an adolescent psychiatrist, it is currently a four- to six-month wait. That is an awful lot of time for somebody to run their car into a tree or get a piece of rope. It is really awful. What else can you do? You can go to accident and emergency but there are no beds in the hospitals. The longest time a person waited ramped in Queensland was a mental health patient who waited 100 hours for a bed. We have serious problems in our health system. It is underfunded and undersized. If your young teenager is threatening suicide, everybody is in trouble.

**Mrs McMAHON:** In terms of preventive care, what does a gold-plated solution for perinatal mental health look like, in the AMA's opinion?

**Dr Perry:** You could start with a reasonable period of time in hospital in the postnatal period. Sometimes people are put out of the hospital by sundown when they have given birth in the morning. It used to be six days for the first baby and five days for the second baby. There would be a lot of advice on breastfeeding. These days, mothers are sent home without breastfeeding starting. There are not always the close family relationships or grandmothers on two sides who are there to help. I am a grandparent with a wife and we both work. We could not really give much support to our grandchildren when they were born. It is a problem. Mothers are often left alone. There are sometimes domestic violence situations. Getting them out of hospital too early is a problem.

**Dr Manoharan:** I did spend a period of time as the director of obstetrics and gynaecology at Logan Hospital, and, as you know, Logan has a very high rate of comorbidities in their pregnant consumers and a lot of teenage pregnancies, obesity and mental health issues. We used to run a service at Logan Hospital to essentially help wean newborn babies off different substances once they had been born. It just shows the level of burden of disease, especially in substance abuse, in that area. The one thing that really helps is not just postnatal care but also prenatal and antenatal care where their usual healthcare providers—in this instance it would mainly be midwives—were trained and able to provide those initial links and supports into a health system to seek mental health support.

If your consumers have low health literacy, if they come from your culturally and linguistically diverse communities and if they are First Nations, there will be a lot of barriers—cultural and understanding and health literacy barriers—for them to access the beginnings of care. Those initial

referral services, particularly through midwifery and obstetrics and antenatal services, are critical. Whether we are doing that right or not you are going to have to ask experts, but it is certainly what we found to be most effective.

**CHAIR:** I would like to thank you both for your presentations today. It has been most useful for the committee. I would like to thank all of the members of the AMA for the great work they have been doing right across the healthcare spectrum. I did pick up on what Dr Perry said in that it has been a fairly difficult couple of years. It has been confusing for a lot of healthcare professionals to see some of the things that we think are fairly basic and self-evident, like vaccination, being so actively contested in our communities and people aggressively pursuing you for putting forward ideas that we think are very sound, very evidence based and very basic to the survival of many people. I thank you for the work that you do. Members may have further questions which we will be put to you via the secretariat. Thank you.

**Proceedings suspended from 12.17 pm to 12.46 pm.**

**CHAIR:** Before I welcome our next speaker, there was an instance of unparliamentary language from Professor Siskind in the hearings on 11 February. I would just note for the benefit of Hansard that there was unparliamentary language. I would now like to welcome Professor Pat McGorry.

## McGORRY, Professor Pat, Executive Director, Orygen

**Prof. McGorry:** I would like to begin by acknowledging the traditional owners of the land on which we meet, the Jagera and Turrbal people—in fact, all the Indigenous people of Queensland—and pay my respects to any Indigenous people who may be present or online and acknowledge their leadership past, present and emerging. I would also like to pay my respects to people with lived experience and their families and compliment the Parliament of Queensland for having this inquiry. It is a very much needed and welcome thing, so I very much appreciate the opportunity to appear before you today.

I am the executive director of Orygen, which is a youth mental health and medical research institute in Melbourne that operates all of the mental health services around a quarter of the city of Melbourne in the 12- to 25-year age group. We conduct a lot of research. I suppose you could say that our work is about building a field of youth mental health. You would be aware from the submissions you have received already how vital this period of transition to adult life is for the onset of mental illness. If you are going to intervene early to reduce the damage that mental illness inflicts on young people, families and their futures, you have to focus on that period. Oddly enough, it has been the most neglected component of the mental health system until the last 15 or 20 years. That is what our work has been about. I have worked in public mental health in Australia for 40 years. I began my training in Newcastle and moved to Melbourne about 30-odd years ago. I tried to combine innovation and research with the provision of clinical care, trying to reform and improve our clinical services so they can catch up with cancer and heart disease and other areas of the health system. We have made some progress, but we still have a long way to go. That is just a bit of background.

Maybe I could just say some more encouraging things about youth mental health. It is the one health problem of young people. It is 50 per cent of the burden of disease in this age group. They are pretty healthy physically these days compared to maybe 100 or 50 years ago even. Infectious diseases—I should not say that in the COVID era—are really things of the past. That was the big health problem of young people in previous eras, but even with COVID it is not really a big issue for them, to be honest. Their main health problem is in the non-communicable disease area, which is the whole mental health spectrum. It is getting worse around the world. We just published a paper in *World Psychiatry*, the No. 1 ranked journal in the world for mental health, documenting the fact that this was a worsening problem even before COVID. COVID has made it worse. It has added another layer of new need and demand for services, estimated at about 25 per cent around the world. It is probably a bit less in Australia.

The main burden of that rising tide due to COVID is actually in young people because of the things that have happened to them in the pandemic: dislocation from their peer group, disruption to their education and even the cloud over their future. This is something that Australia has recognised. We have made some attempts to stem the tide, I suppose, with the advent of headspace, which was an Orygen product. We designed headspace about 15 years ago and rolled out the first few waves; then it became its own entity. We are very involved with it still. At Orygen we operate five headspace centres and integrate them with state mental health services through the Victorian government, so it is trying to create a seamless system. I was listening to the previous evidence about how difficult it is to get access to care for young people. Even with that investment we have made we have 1,000 young people on our waiting list at Orygen for headspace in the north-west of Melbourne. While we treat about 6,000 young people a year, there are another 1,000 at least who cannot get in. That has got worse during the pandemic.

Maybe a dozen countries around the world have embraced this paradigm of youth mental health. What I mean by paradigm is that we have had this traditional paediatric-adult model in mental health, CAMH Services, adult mental health services, and it is a disaster in psychiatry. It is a disaster in mental health because the pattern of illness in mental health is very different to what it is for physical diseases in kids and young people. There are some nasty physical diseases in younger children like leukaemia and asthma, all these sort of things that little kids get, but by and large adolescents are quite healthy physically. There is a subgroup obviously that has physical illnesses, but it sort of peters out a bit. The period of midlife is quite healthy in this day and age, so the physical health services are quite well designed for physical illnesses. As you have all heard, I am sure, in an attempt to get rid of

stigma we decided to put all of the mental health services in with the physical health services about 15 or 20 years ago—maybe a bit longer—but it was not really the right thing to do in the way it was designed because of this problem.

What you have seen in mental health terms is a big surge of new cases of mental illness from puberty through to the mid-20s at least with a peak in the early 20s, yet you have this division in care at age 18 which is really based on legal and educational parameters, not on health parameters. The transition from the child and adolescent service to the adult service 95 per cent of the time is a failure. Even the small number of kids that can get into CAMH Services fail to make the transition to adult mental health care; 95 per cent of them drop out. They are not accepted into adult care because the adult system is designed for the post-asylum cohort, people with chronic severe mental illnesses, most of whom, in the public mental health system, have an average age of about 40. So you have your 18-, 19- or 20-year-olds, even if they do happen to get in, surrounded by people maybe two decades older than themselves. It is a very frightening experience for a young adult to be planted in the middle of an acute admission ward surrounded by 45-year-olds with chronic mental illnesses, so you have to have a separate stream of care which extends up to at least the mid-20s to cover that transition point.

These days, young people do not grow up as quickly as they used to. The maturation process, probably for social and economic reasons, is not really completed until the kid gets to their mid-twenties really these days. Back in Charles Dickens' day adolescence was very short. It might have been between the ages of eight and nine, but these days it extends from probably even before puberty and you are not really a mature adult until you are in your mid-20s on average these days. Developmental tasks are spread out. Also, it is the peak period for new incidents of mental health conditions complicated by substance abuse as well in a self-medication sense. We see huge need, huge opportunity. There is really good research data to show that, if you do actually recognise these problems early and intervene in a fairly intensive way in those early years after diagnosis, the outcomes are much better, a lot of money is saved. It is not like the NDIS, which costs $20 billion a year. You do not get any return on investment for that. Obviously it is the humane thing to do, but there is no return on investment. In this area, if you intervene early it will pay for itself many times over. Governments have been hard to convince about that, even though the data is actually there. They do not really believe it, I do not think. Treasury does not really believe that, probably because everyone says that there is going to be a return on investment. But we know there really is, even for the more severe mental illnesses like schizophrenia and psychosis.

We spent 30 years developing these services, following up the patients and showing that these savings are real. I think it is a huge opportunity. Australia and Queensland are well-positioned compared to other countries to really build this system and complete the building of the system. State governments have a role to play. I read Ivan's evidence on the plane up this morning. He has really nailed some of those arguments. State governments definitely have to lean in, to use his words, and the Commonwealth also has to play a major role, and obviously we have been advocating for some time about that too. I suppose I am saying this is a massive public health problem that, I am sure if you did not already know before you came to this inquiry, you would be convinced of by now. There are solutions. It is not a wicked problem. We can actually do this. I was up here in Queensland on Sunday with the minister launching a new digital program that we developed. It is rolling out across other states as well. These are new innovations that can play a role too. I think we are in a good position. You have great people here in Queensland; you just need a few more of them. The workforce issues obviously need to be addressed too. Australia is the place where this can be done and state governments have a key role to play.

**CHAIR:** Professor, you said that around the world the incidence of mental health issues amongst young people is increasing. Is there any research as to why that is the case?

**Prof. McGorry:** That is a very good question. There is a lot of speculation.

**CHAIR:** All good research starts with speculation.

**Prof. McGorry:** We did a systematic review which is in press at the moment. The evidence is not definitive, but it is suggestive in a few areas. Social media is obviously pretty high up on the list, especially the vulnerability of young women. The mental health of young women, by the way, is actually deteriorating more rapidly than young men at the moment. We have seen this in the pandemic with a rise in eating disorders, especially early stage anorexia. It is just the Wild West on social media, really. There is no regulation. It is a very dangerous place, actually. Even for politicians it can be dangerous, I would hazard a guess. There is no regulation or protection for these vulnerable young people. I do not know what your political stance on these issues would be, but things like: the

insecurity of life for young people now compared to three or four decades ago; the scaffolding around young people making the transition to adult life is much weaker than it was some years ago; there is more freedom for them; there is more diversity, but the clarity and security of the transition is weaker.

What do I mean by that? I would say the casualisation of the workforce, the 10 per cent transfer of wealth from the younger generation to the older generation, sort of megatrends we call them, those sorts of things which are really big things to understand or control. The world is changing in ways which are making life much more difficult for these young people. I suppose climate change is another one that young people themselves talk about a lot. There is evidence supporting all of these risk factors, if we can put it that way, but in some areas you could not say it is conclusive. There are some aspects of social media that are helpful to young people which obviously we have been trying to capitalise on. There can be support systems developed through these new technological innovations, but it is something in a preventive sense we have to understand a lot better. Whether we can deal with some of those risk factors or not, some of them are very challenging, as you can see. It is a bit like heart disease: do you whatever you can in prevention by targeting risk factors, but you still have to have coronary care units, you still have to have cardiologists. It is not an either-or thing. Often in mental health we get into false dichotomies like: why are we spending all this money on treating people when we should be preventing it? It is a false dichotomy. You have to do both.

**CHAIR:** Your opening statement has dealt a lot with your work in Orygen and young adolescents and the mental health space, and I know you worked extensively on the Victorian royal commission. Could you provide a bit of an overview of the systems changes or the challenges you were dealing with there and some of the solutions that were put forward and how they might be relevant to Queensland?

**Prof. McGorry:** That is a great question. Yes, I chaired the expert advisory committee for the Victorian royal commission and I have worked in adult psychiatry as well. I started off emphasising the youth mental health thing, but I am very happy to talk more broadly about mental health.

What happened is a bit of a paradox. In Victoria and in Australia generally there has been a tremendous increase in interest, understanding and awareness of mental illness and mental health over the last 20 years. Also you could say the federal government—and I am sure Harvey Whiteford is going to talk about this—has grown to some extent the primary care capacity with better access and more training for GPs and some of the things the AMA people were talking about. If you look at the OECD figures, we are actually doing in the high end of the OECD in primary mental health care—and headspace is another example. Headspace is a success; we have covered most of Australia with these entry points for young people. There has been growth there. At the same time at the state government level there has been a decline in real terms. State governments are supposed to fund—this is just a convention—three per cent of the population with serious mental illness. They are supposed to cover those people with the more severe, complex illnesses.

In Victoria we were probably a bit closer to that back in the late nineties but it just declined and completely fell apart. We have been trying to tell the government for the last 10 years that this was actually happening. Of course there has been huge population growth in Victoria as well. The system was just completely overwhelmed. Because the resources have been put into the big hospitals to run in a block funded way, they sat there like a cash cow. Even though it was already underfunded, the CEOs of the hospitals just dip into that bucket of money whenever they are running short. There was no protection; there was no ring fencing of the funding. In particular, the community mental health services were raided and dissolved and were overwhelmed with demand, so they collapsed. Now everyone is in the emergency department having terrible experiences because it is not the right place for people with mental illness. That is no reflection on the emergency department staff. It just is not set up for that and it cannot really be either. That is what happened. It imploded and our Premier described it as a broken system, and that triggered the royal commission.

The royal commission was amazing. They claim it was the most subscribed public inquiry in Australian history in terms of the participation of the public. I am not sure if that is true, but I have heard that said by the government. Certainly there were thousands and thousands of submissions and round tables and the public actually engaged and shared their experience of the mental health system. The same happened with clinicians and researchers. It was very inclusive and was brilliantly chaired by Penny Armitage, who was a senior bureaucrat in Victoria. The Premier was 100 per cent behind it; that was the other key thing. They said that they would implement all of the findings when they reported and they have honoured that. They are determined to do that and they have put $3.8 billion into rebuilding it.

The money that they are going to spend will probably just bring us up to the three per cent. You still have this missing middle thing—the moderate cases that still fall between the cracks—but this is going to be a very big improvement. The blueprint they came up with was treating the

community as the centre of gravity of care and not necessarily commissioning the big hospital networks to be the providers of these services anymore was a bit of a breakthrough. I think the game is up for hospital boards and CEOs to basically rip off mental health—in Victoria at least.

**Ms CAMM:** I just had a headspace open in my local community.

**Prof. McGorry:** Great.

**Ms CAMM:** It is a shame it took 2½ years to hit the ground once they announced the funding for it.

**Prof. McGorry:** The PHNs are very slow.

**Ms CAMM:** It is the way government funding and structure flows. My question is around adolescence. As you explained, that period of adolescence has extended and girls are entering puberty earlier—and I am very interested in that particular cohort—such that they might be embarking on puberty now from age eight or 10. Their biochemistry is changing, their physicality is changing and there are all those sorts of contributing factors. We asked this question of previous panellists as to what are the contributing factors. Has any research been undertaken in particular cohorts where we are seeing that growth?

**Prof. McGorry:** Do you mean early puberty?

**Ms CAMM:** Yes.

**Prof. McGorry:** People at the children's hospital in Melbourne have been studying this with my colleague George Patton. Those children who experience puberty early do have a higher risk of mental ill health, so it is a good thing to bring up. The other corollary of that is what is the right way to deploy mental health services for children and young people? It is a cultural thing. What is culturally right for them? Do they feel comfortable? Adolescents do not feel comfortable in children's services. They see themselves as emerging adults. You have to draw the line somewhere. Eight or nine is probably a bit too young to be thinking that way. It should be a little bit flexible so the young person can have a say in it themselves. That is how we have designed these services. We have involved young people in the co-design of these cultures of care, whether it is headspace or the specialist services like Orygen, and the parents, too.

I have to say it works incredibly well when it is roughly 12 to 25 in an outpatient setting. In an inpatient setting you probably have to structure it a little bit differently so that the younger end of that spectrum has a different space from the young adults. That is the age group that go to rock concerts these days. If you go to see certain bands, that is the age group; it will be those aged about 12 to 25 who will go to certain music venues. Culturally, it has to be designed like that.

The other reason for designing it that way is that the content of mental illness or mental ill health prepuberty is different from it post-puberty. Puberty is like the Rubicon beyond which you start to get adult type disorders like psychosis, depression, anorexia, borderline personality and substance abuse. In little kids it is ADHD, conduct disorder and autism—a different pattern of morbidity. Also different professionals are needed. There is a lot more need for paediatricians to be involved, for example in the younger children area, and I would say much less of a need in the adolescent group—certainly the older adolescent group.

Also parents can bring little kids to a centre. There is a lot more agency and autonomy, which you want to encourage in the adolescents and adults, too. The attitude and culture of care is different in the two groups. It is a very important consideration. Then they will engage. Anyone who has adolescent kids knows that a bit of a gift or a skill is required to engage them, and not everyone has that talent. You need a special type of workforce as well to work with that age group. You have to love them to work with them.

**Mr O'ROURKE:** In your submission you mention the 500 new medium-term housing units for youth. Can you advise what level of support is provided in those facilities? Is there a case management practice that exists with regards to transitioning those youth out of that accommodation into something else?

**Prof. McGorry:** Thank you for bringing that up. It is the whole residential side of things. You need a suite of options when it comes to the residential side of care. Obviously at the top of the pyramid is the acute inpatients unit, which again has to be a safe space and has a certain role. In Victoria we have these things called Youth PARCs, which are sort of recovery centres which have a longer tenure of care. You could stay for a few weeks—probably as an acute inpatient, it would be a couple of weeks. Then you have this step up, step down subacute type model which they call PARCs. There are not really long-term equivalents of the old mental hospitals. In adult psychiatry they have these community care units where you can stay for long periods. Then people like Allan Fels have

developed models like the Haven Foundation, which you might have heard about, which was developed in an NGO sort of way. There are other models in the NGO world, too, for longer term residential care.

What the Victorian government has done in the budget is allocate 2,000 places in public housing for the mentally ill of which 500—I think that is what we are referring to here—were allocated for young people. It is obviously a crucial thing. I think in Ivan Frkovic's evidence and John Allan's evidence, which I also read, spoke about the fact that there are bed blockages with people in the acute inpatient units in Queensland who do not really need to be there from a clinical point of view but they have nowhere to go. Sadly, all around Australia people with serious mental illness are kicked out of acute inpatient units with nowhere to go. The housing side of it, which I am sure you have heard a lot about in the inquiry, is another key investment that government could make which would help a lot.

**Dr ROWAN:** I want to come back to some recommendations you might have for this committee around population health programs and your experience at a national level and also in Victoria. You were talking before about social media, insecurity and the mega trends as far as volatility, climate change and other matters are concerned. In relation to programs around building resilience for families or programs within schools or the broader community, are there specific things that Victoria has looked at or have been done nationally that Queensland could do to try to strengthen that at a population health level? We know that one region is one region, so things need to be customised because there are particular socioeconomic demographics or different populations or discrete populations. Do you have any thoughts on that?

**Prof. McGorry:** That is another great question. What Victoria has done is invested more in clinicians in schools like GPs, doctors and allied health professionals. Some of those are employed in headspaces and they work in the schools and in headspace, which is a fantastic conduit. I think peer support programs in schools can also be a very trusted thing for the kid to relate to one of their peers who has been trained in listening skills and mental health first aid. They can also be an ambassador or a bridge to a clinician. School counsellors tend to have a bit of stigma or labelling attached to them, so you have to do it in such a way that it is normalised.

There is a lot of people jumping on that bandwagon of resilience training, to be honest, and trying to market themselves in that space but with very little evidence behind it. If you think about what resilience actually is—I think Julia Gillard described it as an outcome. Obviously some people are intrinsically more resilient than others. Resilience is what you get in relation to adversity. If you have led a charmed life you are never going to be able to demonstrate resilience. It is like a process in a sense.

To be quite honest, I have not seen any evidence about effective training in trying to import resilience into people. I might be wrong and I stand to be corrected, but certainly I have not seen it. It is usually used as a way of diverting attention from the needs of the kids. We have done surveys of Victorian teachers. On average, teachers have been exposed to the suicide of at least one child in their care; sometimes multiple. The teachers are very aware of the mental health needs of the kids in their classes. What they cannot get is backup to help them deal with it. Beyond Blue has done this thing called Be You, which is like an online resource for teachers, but again it is down the shallow end of the pool. I do not believe it is actually meeting their needs. I am not saying it should not be done but something else needs to be done as well. I think it has value. That is a key thing.

This is in the submission that we sent: the key thing you could do in Queensland is what Victoria has just done through the royal commission, which is to lift the transition age from 18 to 25. I might have implied that before. If you did that you would line it up with the headspace system and you could integrate in a much better way and it would be a lot safer. You would have to provide resources for it because if you just change the age range without allowing them to actually have the resources to look after those 18 to 25-year-olds, it obviously would not work. There is benefit for the adult system in doing that because the adult system then does not have to look after those 18 to 25-year-olds. You could say it is cost neutral, but you cannot take resources off an underfunded adult system so you probably do have to put in new resources to make that happen.

**Ms KING:** Thank you so much, Professor McGorry. I have really enjoyed listening to your submission and reading what you provided to the committee earlier.

**Prof. McGorry:** Thank you.

**Ms KING:** Can you comment on the particular challenges Queensland faces as a geographically dispersed and decentralised state? Clearly Victoria has at own different challenges but it does not have that one so much. I want to hear your thoughts about how to ideally integrate

online and face-to-face services. That might include MOST, which you have provided some submissions about. More broadly, is integrating online and face-to-face care a pathway or do we need to be looking at other things?

**Prof. McGorry:** Thank you; that is a brilliant question. I think a comment I read in one of the submissions was that you can drive across Victoria in a couple of hours. Even there the regional centres have major problems with workforce and recruitment. I think it is an Australia-wide and probably a worldwide problem. In some ways you might think that Queensland could have an advantage because your regional centres are much bigger and better developed and you have more of them. I do not know if that is true, but it struck me that in Victoria there is really only one city and there are a couple of very small regional towns. It is very centralised whereas you are decentralised. I think that is a massive problem, the rural and regional workforce issues and how to deliver quality care.

It is also a problem in the outer metro. In Melbourne, because of the shortage of mental health professionals and the underfunding of mental health they all cluster in the leafy suburbs. Where we work in the north-west of Melbourne, there are very few private practitioners and the capacity of the people who live there is very low for paying the co-payments that private practitioners charge. There is massive inequity even in the outer metro areas of the capital cities. Definitely rural and regional Australia is probably in an even worse situation.

What is the solution? Obviously digital is part of it, as you said. We are very grateful to the Queensland government and the Children's Hospital Foundation for funding the first stage of the rollout of this integrated platform that is meant to be complementary to face to face. It is not meant to replace face to face; it is meant to be for in-between appointments, for people on waiting lists and for when people have maybe been discharged from the service, as a safety net for them. It is a mixture of a social network so the young people involved in a particular platform can help each over. There is a whole lot of resources where they can map their own strategies and journey of recovery. There is lots of resource material and other experiences from other young people. It is peer moderated and clinician moderated. It has been developed over 10 years with NHMRC funding and has a huge amount of evidence behind it. Now it just has to be implemented in the real world alongside the clinicians. That could be a key thing and it could be available in much broader settings like schools or general practices. It could be adapted to lots of settings.

Face to face is very important. We are human beings. We have all experienced through COVID how much nicer it is to be in the room. That is why I came up here today; I did not want to be on Zoom. It is much better to be in real life and in contact with each other. We need that. Especially when you are suffering and you are distressed and you are losing hope, you need to be able to feel the person and get that feeling of care and empathy from the person in real life as well. I do not think you can let that go, but you can complement it with digital.

With the workforce, we have to widen the bandwidth of the workforce massively, that is, new Commonwealth funded places and do everything that we can do to expand the workforce and also to make them more skilled and able to deliver the new evidence that is appearing. How do you incentivise people to work in rural and regional Australia? I think that is above my pay grade. A lot of people have tried to solve that problem but there must be a solution to that. We have to find a solution to that. Maybe we should try to decentralise more generally and have larger regional cities. That might be a way of doing it. I heard the AMA doctor saying that when professionals move to those areas they want to make sure that their kids have a good education. One of the key variables I have heard from practitioners is that they want to be able to ensure that their kids get a good education. There are probably things that you would know more about than me that should be thought of in that respect.

**CHAIR:** I want to pick up on your commentary around the age range of services. We have heard evidence and received a submission from the Mater in relation to their young adult service, which is not exclusively mental health or physical health; it is just a service. Are you aware of that service and could you comment on whether that is the sort of model that you are proposing?

**Prof. McGorry:** I am a little familiar with it. I think we have to have physical health integrated within our specialist mental health care system. It has been another neglected thing, even though we are trained as psychiatrists. I did four years of general medicine before I did psychiatry. We are doctors but a lot of psychiatrists just leave it in the bin. They do not actually retain it or think of it enough, I do not think. GPs are very important. Even when GPs are treating people with mental illness often they will zero in on the mental illness and ironically neglect the physical health of the psychiatric patient. I would say substance abuse is another thing that has to be much more tightly integrated into mental health care because people do not operate in silos. They are people so a holistic approach around all of those issues is really important.

What I think would be ideal would be if the current CYMHS system could be separated into two zones: the primary school and below, and the secondary school and above, up to mid-20s, and within the youth zone of that space—and probably in the child one, as well—you have physical health care prominent as well. You have paediatricians involved, you have GPs involved and you encourage the psychiatrists to think in a more holistic way.

**CHAIR:** Often it was a bugbear of mine, in the limited work I have done in the mental health space, that people say not to worry about the smoking, the drinking or the lack of dental hygiene because they are not here for that problem.

**Prof. McGorry:** That is exactly right and that is why people with mental illness die 15 years younger than everybody else. I have a son who has a serious mental illness. He has been successfully treated with clozapine, which is underused and often used too late as a drug in mental health. It has made him put on weight and he has metabolic problems because of that. I am not sure whether he is getting enough preventive medical care for those conditions, which could shorten his life. He has given up smoking and he does not drink or take any drugs, which is great—I am very lucky in that regard—but I am worried about his physical health.

**Dr ROWAN:** Professor McGorry, I want to ask a very specific question about some of the innovative or new technologies and the role of the public health system around that. One of those would be non-ablative neuromodulation, so deep brain stimulation, for refractory eating disorders or for depression and also the role of transcranial magnetic stimulation. I ask that in the context of looking forward in relation to those newer modalities that are being looked to be implemented and the evidence base around those. What are your thoughts about the funding for those in the public health system, what is happening in other state jurisdictions and what should be considered given that this is a wideranging inquiry into mental health in Queensland?

**Prof. McGorry:** Thank you for that question too. I will start off with a general point: we need innovation. One of the problems is that the drug companies, which get a bad rap in mental health, have abandoned us basically. Everyone thinks that they are trying to take over and exploit us, but actually they have almost given up on developing new treatments. We are having to attract them back into the discovery space because we need safer and better treatments from a drug point of view.

On the psychological side, there are innovations like IPS for vocational recovery where you put the vocational workers into the mental health service alongside the clinicians. We get dramatically better success rates in vocational recovery if that is done. It is not done in mental health services anywhere at a state level. Those workers should be there, otherwise the kid just gets sent off to the job network, disappears without a trace and basically never gets a job. People with mental illness need that specialised help and it has to be within the same service. We have had rates of 95 per cent vocational recovery for people with schizophrenia and psychosis, which is unparalleled, just because of a change of model and a change of expertise. That is one thing. It is not new but it is just not implemented.

There is definitely a very strong evidence base for TMS now. It should be in every mental health service for even early treatment resistant depression and anxiety. We have it at Orygen now and I have referred quite a few young people who did not get better with antidepressants or CBT, but they have got better with TMS. It is a very promising treatment. I am not really that knowledgeable about deep brain stimulation, but I know it is a growing area so it is probably definitely worth the committee looking at a bit more carefully.

Then there are things like virtual reality. You have all heard about CBT, cognitive behaviour therapy, which is incredibly boring if you are a patient. You get given all this homework about you are not thinking straight and if only you train yourself to think in a better way you would not be depressed. It does work and it is evidence based, but it is not the most thrilling experience of your life. How can you make it more engaging for the actual consumer and the patient? Virtual reality is the way to do it. You can put the person in the real-life situation that they are having difficulty with, for example, going to a shopping centre or mixing with people. If they are a bit paranoid about getting onto a bus or a train, you can put them in that real-life situation in a very vivid way and use the greater exposure and reprogramming or cognitive strategies to help them deal with the anxiety in vivo. It is bound to be much more effective and it is very useful already for things like PTSD and other conditions like that, but it has much wider applicability. We have a studio for that now. It might be able to be devolved into smaller clinics as well, with new technologies.

Innovation is necessary across the spectrum, whether it is in psychological, social or drug and biological therapies. The reason it has been slow is that there are two problems. One is that even things we make advances in do not get implemented, like the IPS and the vocational thing. We are

poor cousins in medical research as well as in investment in health care. We do not get a fair share of the medical research pie. We get about seven per cent of the NHMRC budget when we are at least, arguably, up to 18 per cent of the burden of disease. Cancer gets 30 per cent. Obviously no-one wants to get cancer and I am not saying not to invest in cancer, but with some areas it is not equitable. Affirmative action for research would help your question, I think.

**Mrs McMAHON:** There are two areas I wanted to have a look at. Firstly, in relation to workforce, I have no doubt that our workforce challenges are probably not too different to what was happening in Victoria in terms of the inquiry that happened down there. In terms of flexibility of workforce and scope of work, I know there are shortages in all aspects of the mental health workforce, but are there opportunities for expanding scope of practice within some of our workforce that are quicker to train? I know there are many blockages within the tertiary system for really specialised at the acute end, but in terms of our nurses and allied health, is there opportunity to expand scope or the workforce capacity in the short term with only minor training interventions?

**Prof. McGorry:** That is another very appropriate and timely question. I am sure you have heard of the concept of micro-credentialing. That is what we need to do, I think. At Orygen, we run university courses for youth mental health of various kinds, including for psychiatrists. We are becoming an RTO so that we can do micro-credentialing so that you can train people who are perhaps already partially trained—let's say four-year trained psychologists, or people who have a counselling or psychotherapy background, but on their own or through associations do not have national credentialing. We could do a bespoke course to bring them up to a certain standard. I think that definitely could be done.

I am sure you have talked a lot about peer workers. We have youth peer workers in our headspaces and at Orygen. They are very useful and valuable. Youth workers is another group that I have found in some of the headspaces that I have worked in to be really invaluable. What they need is an extra dose of mental health training on top of what they have been trained in because they have great engagement skills. Even volunteers, to be honest.

In the Netherlands, I saw the equivalent of headspace which is called @Ease. They have university students coming in as volunteers in shifts who sit around in a big foyer in the service and have a coffee and people can drop in and have a listening ear. If those volunteers who are trained think that they need to see a clinician, they take them out the back and get them to sit down with one of the clinicians. It is that flexibility. I call it 'the sponge'—absorbing the sponge of demand from the community in a way that feels safe for them to come in. The sponge can be squeezed: they can squeeze back out again if they do not need to stay or they can squeeze in. You need the right culture, the right facility and the right people sitting in that sponge area.

**Mrs McMAHON:** The other area that I wanted to have a look at was with youth mental health, where you do a lot of work, and acknowledging your submission talks specifically in the 12-plus area. I want to look at some of the earlier years where our kids are maturing earlier, they are going into high school settings earlier and they are being engaged in a lot more riskier behaviour and are under a lot more influences a lot earlier than they used to. What could or should we be doing in the under-12 space? I note the headspace limitations in terms of your scope is 12 and above, but what do we have for our younger kids and what do we need for our younger kids?

**Prof. McGorry:** That is a great question. In his previous role, Ivan Frkovic-, who is sitting there, and one of my colleagues in Melbourne who used to work with Ivan in Queensland, set up a service called The Poppy Centre at Meadowbrook, which was like a zero to 12 version of headspace. The federal government has now taken up that idea with these kids' hubs that they are starting to fund. That is the sort of thing you probably need to do for that age group.

Reflecting on your point, what I have seen from working in headspace with kids from 12 and up, they seem to fall into two groups. One group are the kids who have been okay until they reach puberty or into high school and they start to develop the early signs of mental ill-health from, I would say, year 7 and 8 onwards, although they have been okay in primary school. That is about two-thirds of the kids that I see in headspace. The other one-third would have needed much better help in childhood. These are the kids with the more hard-core social backgrounds like foster care, out-of-home care, child sexual abuse—really terrible experiences that a lot of these kids have had—and they have not been helped properly.

The damage has come from not only trauma but also from attachment damage where they do not have a proper parent. They have 15 parents for six months. Those kids are definitely salvageable if you provide services in adolescence that mitigate that damage, but it would be a lot better if they got help when it was happening in earlier childhood. Then there are the more specific syndromes or

disorders that we see like ADHD which is controversial in some settings. It is probably over treated in some ways, but then a lot of the others are missed as well. We need expert teams to treat those treatable conditions.

Autism spectrum is another one that we see a lot of coming through into adolescence. It has not been helped much in childhood. Again, those Poppy Centre type things have to be configured in a way that meets the needs of that have stage of life and the problems that present, and it is very different from what you would see in a headspace.

**Mrs McMAHON:** With regard to schools as delivery vehicles for some of these, did you make any recommendations or findings in Victoria in relation to the role that schools can play in delivery for this age group?

**Prof. McGorry:** There was some of that in the royal commission. Especially in rural and regional Australia, what I have noticed is that even when you have a headspace in a reasonably sized regional town, a headspace would be justified in a town of, say, 20,000 to 30,000 people up. Below that, there are not enough kids to justify a whole headspace, so satellites is one thing they have done. Public transport is a big problem in these areas that I have worked in.

I work in Coffs Harbour in New South Wales once a month and it is great for the kids who live in Coffs Harbour, but if you live up the valley, there are buses twice a day—you cannot get there. A school would be a great venue for satellite or pop-up type services because it is a piece of real estate that the kids can get to, and do get to, so you could use it maybe after hours for pop-up clinics. That flexibility and agility is what we need to think about. It is a really good idea.

**Mr MOLHOEK:** Professor, in the few minutes I have been waiting to ask my original question, I have come up with about 10 others I would really love to ask. Could you comment on other programs like wilderness experiences, boot camps, adventure based activities where a bunch of young people will go and spend, say, a week with some instructors and the like in an intensive experience, or even programs like Rotary run with RYLA? Do we need to do more of that sort of thing with some of our young people who are struggling with identity and some of these other issues? Are they worthwhile?

**Prof. McGorry:** Thank you for bringing that up. I think they are definitely worthwhile. I mentioned Coffs Harbour. We have had some great discussions with the Southern Cross University and there are some real experts in that area of work there. They are based on the Gold Coast, I think—the people, as part of Southern Cross. They talk about not just adventure therapy, which we have had at Orygen as a component of our group programs, but natural therapy—in other words, the wellbeing and the positive effects on mental health you can get from being in natural environments, like close to nature. ‘Blue and green spaces’ is the jargon that they use.

There is quite a lot of research on this showing the benefits of it. It is like a mental health promotion thing. It is not a treatment for mental illness, but it improves the mental health and wellbeing of people. You can have pretty good mental health, ironically, even if you have a mental illness. You can have a feeling of wellbeing, even though you have symptoms and disabilities. You have probably seen it with people with physical disabilities. Dylan Alcott has fabulous mental health, has he not, even though he is quite disabled? It is the same with mental illness. You can improve the mental health and wellbeing of people even though their mental illness might be pretty much the same. It is definitely an important thing for us to be doing.

**Mr MOLHOEK:** You also touched on some child safety issues and issues like multiple placement syndrome and the lack of attachment—all of those things that come through from being moved around from foster family to foster family, and then there are the residential care programs where it is just two adults rostered on 24/7 with a manager.

**Prof. McGorry:** Yes.

**Mr MOLHOEK:** Create Foundation have talked in the past about the fact that when kids turn 16 and they have more rights around choice—I cannot remember the exact figure, but I think it was upwards of 80 per cent of kids elect to go back to their original dysfunctional family, warts and all—would we be better to redesign the child safety system so that it wraps services and support around that dysfunctional family so that more children could actually stay in place with their family or with their mother predominantly?

**Prof. McGorry:** I would not claim to be an expert in child protection, but one thing I could say is that a lot of the kids that come from families which are regarded as dysfunctional are families where those with untreated mental illness or poorly treated mental illness and addictions are the parents. In a way, you could make what you are talking about more possible, apart from more support for the

kid, by helping the parents. In a way, the failures of the public mental health system around Australia—which I started talking about, the kind of decline of public mental health care post institutionalisation—obviously it was not good when we had asylums, but institutionalisation has not worked. It was poorly designed and it has failed really because of poor investment and poor design.

Because of that, the care of the adults who are having the kids has been terrible. A lot of kids have suffered because the parents with addictions and mental illness have not been looked after properly. That is a preventive thing that could be done for those kids as well as the more wraparound supports to help the kids stay in their families, as you say. There are also kinship models within child protection which are favoured above pure foster care models, I think—that is what I have heard. I would not claim to be an expert in that space. We did some research of kids in out-of-home care which showed the incredible level of psychiatric morbidity in those kids.

**Mr MOLHOEK:** To ask a broader question, there has been a lot of discussion around early intervention; the Mental Health Commissioner has talked about from zero to six. My observation is that some kids can come from incredibly dysfunctional families and go on to do amazing things and have incredible lives, and other kids can come from the best of families and end up quite dysfunctional, and four kids from the same household can all turn out completely differently. How do you design systems around that and how do we work through that labyrinth of complexities with young people?

**Prof. McGorry:** That is a very good question. If you have a think about what mental illness is, it does not discriminate. Affluent people can have it. Kids from affluent backgrounds can experience mental illness. That is because the causes of mental illness are multiple. It is multifactorial. There is genetics involved; we have all got it. There was a study in New Zealand following kids from primary school through to the age of 45. They were followed intensively and interviewed every year or two. 84 per cent of those people developed a diagnosable period of full mental ill health and two-thirds of that was significant, being moderate to severe.

We are all potentially at risk of having mental ill health. If you have a lot of risk factors piling up, as experienced in disadvantaged communities, you are more likely to have it from those communities, but it does not mean that middle and upper-class communities are immune from it. It is still at a pretty high level even in people with all the advantage in life.

There is genetics. Not having disadvantage does not protect you from adversity in life, does it? Adversity can happen for a whole variety of reasons. I suppose what I am saying is that we can explain it. The medical research explains why that is the case, what you are describing.

**CHAIR:** Thank you very much for your attendance today. We do appreciate that you have come all the way up here. It has been very beneficial. I think, like everybody else in the committee, I have a dozen more questions I would like to ask you. Members of the committee may choose to send you additional questions. We do really appreciate the work that you have done in your time in Victoria and we hope that we can benefit from it here in Queensland.

**Prof. McGorry:** Thank you very much. It has been a real privilege to meet you all and to talk to you. Every good wish for your work.

**KING, Dr Stephen, Commissioner, Productivity Commission (via videoconference).**

**WHITEFORD, Professor Harvey, Private capacity (via videoconference)**

**CHAIR:** I welcome the Productivity Commissioner and Professor Whiteford. Would you like to give an opening statement, Professor Whiteford?

**Prof. Whiteford:** Thank you very much for this opportunity. I thought I would explain the context in which I am appearing. I am a psychiatrist by training but I worked as the Queensland Director for Mental Health for about seven years in the 1990s. I then worked for the federal government in Canberra for the renewal of the second national mental health plan for two years. I then worked for the World Bank for three years to establish their lending program for mental disorders, substance abuse and neurological disorders.

I returned to Australia and took up an academic position at the University of Queensland. I am a professor of population mental health in the school of public health. We do research around the epidemiology and burden of mental disorders, the service planning and treatments for mental health problems, including the National Mental Health Service Planning Framework that is funded by the state, territory and Commonwealth governments for use by government primary healthcare networks to help them in planning mental health services. That is the expertise that I bring to the inquiry. I can also say that for 18 months I was a commissioner on the Productivity Commission mental health inquiry. I completed that role in about August 2020. Dr King was the lead commissioner on the inquiry.

**CHAIR:** In relation to your academic role around population mental health, we have heard a lot in this committee about the need for early intervention and preventive programs. In your view are there opportunities there for us to take advantage of in trying to deliver preventive health programs at a population level?

**Prof. Whiteford:** The short answer would be yes. There is an increasingly good evidence base that early intervention is an effective way of preventing individuals with early mental health problems from progressing to more significant mental health problems. The issue is really understanding that continuum from risk factors in the community, which fall outside of health departments usually but are an important part of other community services and social services that support families, through to primary care, specialist care, hospital beds et cetera. If you do not get that balance right then a lot of the pressure ends up further down the system in acute care whereas the evidence is that we could have intervened earlier if we had the knowledge about what worked for whom and at what time.

**CHAIR:** Would you be able to give us some examples of the sorts of programs that might work based on evidence?

**Prof. Whiteford:** Certainly. Earliest intervention is assisting parents. One of the Productivity Commission recommendations was around screening for families to assist them. We do screening for a lot of physical health conditions, for preschool children, for hearing, for vision and for other developmental milestones. We have not yet screened for psychological or social development. Whilst we are not trying to diagnosis mental illness when we do this, we know what the trajectory is for the development for children and there is good evidence now that we can detect individuals whose developmental trajectory is not as it should be, that is, as is their peers. There might be reasons for that but there may not be. If we can identify that and then assist the family, because that is the unit that is really important, you can help get that child's development back onto a trajectory that would mean some of the challenges they were going to have in school or as adolescents are likely to be avoided.

**CHAIR:** Dr King, welcome. Would you like to make a brief opening statement?

**Dr King:** No, other than that the Productivity Commission report I think speaks for itself. We have been doing some other reviews since then, but hopefully some of the recommendations will keep moving.

**CHAIR:** The topic of planning and co-commissioning of services has come up frequently during the evidence that we have heard, particularly today, but also in previous hearings. Does the commission have a view around how that should be progressed? Is there a model that you advocate, or is it merely up to each region and state to work out the best way to do it in their circumstances?

**Dr King:** We presented quite a detailed third model from our perspective in the final report. We strongly encourage or recommend local coordinated commissioning across local regions, so working out what the needs are and making sure that the co-commissioning can meet those local needs. The approach that we took was to note that we have currently got the PHNs and you currently have the HHSs in Queensland—the local hospital districts. Often they are not coordinating with each other particularly well.

As a consequence we found significant gaps in services in parts of the country. We suggest that while it is up to each individual state, the starting point should be coordination between the HHS and the relevant PHN—and some PHNs overlap with more than one HHS in different states, although I think it is a bit cleaner in Queensland. It is about having that interaction formalised, making sure that there are jointly set targets, making sure that the funding priorities are jointly set between the groups, that they report on those jointly set targets and progress is evaluated against those.

If those are unsuccessful or if the state currently believes that that separation between PHNs and HHSs is not appropriate, then we suggested that the alternative would be to 'pass the money' from the PHNs to the relevant state body, which would be the HHS or a new body that was set up by the relevant state government. That single body would do the regional planning, regional funding and the reporting. The reporting would all go back up in our framework to the National Mental Health Commission which would be an independent statutory authority and therefore separate from any state or Commonwealth government.

**Dr ROWAN:** Professor Whiteford, congratulations on all of your work, in particular being the inaugural chair of the Queensland Mental Health Commission Mental Health and Drug Advisory Council when it was originally set up. It was a pleasure to join you on that. There has been a lot of discussion in relation to coordination, integration and collaboration. We have had discussions at this committee and in testimony about whole-of-government strategies and governance structures that can drive some of these collaborative reforms across the sector. In your various roles, and again through the Productivity Commission but also in various departmental roles and other positions, is there anything that can be done in Queensland specifically to drive that around whole-of-government structures? Perhaps that is having things like a minister for mental health sitting at the cabinet table. How do you get that cross-departmental collaboration? Are there any things being achieved in other jurisdictions in Australia or internationally?

**Prof. Whiteford:** Thank you for the question. It is the question which I think has challenged governments and planners for a long time. We are into our fifth national mental health plan at the moment. We should have a new National Mental Health and Suicide Prevention Agreement coming soon. The reforms, which have been top down largely, have achieved some things. However, now we need reforms that are actually based in the community and grow from, as Dr King said, an approach where we forget a little bit about who funds this and look at what the population needs.

If you take a population—it could be Metro North or it could be the Torres Strait—we can know from the data the likely epidemiological prevalence of major mental health problems that are going to need intervention. That modelling has been prepared and funded by governments and it is available. Then we need to look at what exists on the ground now. That is the bit that is often not done. There are private sector, primary health care, state government and non-government agencies, charities and a range of interventions. No-one sits down and collects those and looks at what exists now and then looks at the gap between that and what the service planning framework says we need for that population, which may have some confidence intervals about it but it gives us an understandable gap between what we think the need is based on best practice and best evidence, and what we have now. We would know where the gap could be the greatest—maybe it is children or older Queenslanders—and the distance to get that gap closed.

I think it would be fair to say that doing those gap analyses, when we first started looking at them, was scary for governments because the gap was reasonably large. What I say in response to that is that even if we had that budget, which we would not get, we could not use it because we do not have the workforce at this stage. We could use an incremental closing-the-gap approach, but be accountable for getting there and accountable for spending that across the board.

To do that, to answer your question, you do need to have a working relationship with the other players, whether they are funded in the private sector or in the state or territory sectors. That is how I would approach this and it is what Dr King was referring to. I think where we have done that around Australia we have been successful. It is a more efficient use of the resources because not only are you able to better identify the gaps but also you are able to better identify areas where there are one or two or three providers working in the same space but not coordinated. I think we can do that. The recommendation has to be that we have to think about Queenslanders and not about what Queensland Health does or what the PHN does or what a particular non-government organisation does. We have to focus on what the population that we have identified needs as far as services.

**CHAIR:** When I listen to that—and I have read through various submissions—it seems to me that we talk a lot about new models of care, extending scope of practice and all those sorts of things—and that may well have a place in it—but it actually sounds like the connectedness and the coordination of the existing system leaves a lot to be desired. Is that a fair estimation?

**Prof. Whiteford:** Unfortunately, I think there are inefficiencies in the system and we do not use the existing services in the most efficient way. Where we have, in my academic role, mapped jurisdictional services on the ground and identified them, located them and coiled them together, they often did not know each other existed. Consumers have told us they have had seven, eight or nine case managers in various components who do not know about each other. There is that inefficiency. We can talk about different silos of services, but if you require those providers to plan together for the same population then they are sitting around the table thinking, 'What do I do? What do you do? How do we fill that gap? How can we do better?' Getting that communication between the providers is critical. Setting a structure that requires that, as the Productivity Commission report does, is one way where I have seen that start to work.

**Ms CAMM:** We heard today from Queensland Health and from our primary health networks evidence that was in direct conflict with each other with regard to the resourcing to empower HHSs across Queensland. Who should lead this? You have the findings of the co-design. We know as a decentralised state the finite resources we have. This morning we heard from the head of Queensland Health and it was his view that they were resourced and empowered. We will hear more about that, I am sure, from HHSs directly. Both levels of government hold the purse strings. One has more influence over the workforce; one has more influence over larger buckets of money. When we talk about needing communities to sit down, work together, collaborate and build relationships, we also need leadership. Who do you think is best placed to provide that leadership? What would be your recommendation there?

**Dr King:** Our recommendation was that leadership is needed from the state, territory and federal governments. Our recommendation was that there needs to be a new whole-of-government national mental health strategy. That needs to make it very clear who is responsible for what, who is funding what to make sure that the gaps are filled and how that strategy is going to be reported against. We view the National Mental Health Commission as being in the best position to provide the oversight for such a strategy. I certainly know from the Productivity Commission's perspective, because we were asked to do an initial audit of services, that things started moving forward on that strategy. Unfortunately, I am not sure where it sits at the moment.

**Ms CAMM:** Thank you. That is a question I will place on notice for the Mental Health Commissioner. Did you look at the role of local government in contributing? When we say 'all levels of government', local government is at the coalface and does understand its community and normally there is not a political interest, particularly in regional areas, because there is no political affiliation et cetera. Is that something that the commission considered or received submissions on?

**Dr King:** Yes, we did. We did not consider that local government would be part of that whole-of-government strategy explicitly—it would not be a signatory—however, local government, together with the state government, has a significant role in providing local services. To reiterate what Professor Whiteford said, we need to make sure that the structures are in place for that at a local level, at a regional level, and that we are able to work out what services are being provided, where the gaps are and how to fill those gaps. We do not see a national strategy as being top-down; we see it as being very much bottom-up, and local government is part of that. Local not-for-profits who are providing services are part of that. Smaller community health providers are part of that. Unless we get everybody at the table working together, we will end up with gaps and people missing out on services that they should be provided with.

**CHAIR:** Taking on board what you have both had to say about the need for coordination, planning and commissioning of services locally, if we start to unpack things a bit as the current system exists here in Queensland, general practice services are really the first port of call in terms of diagnosis and initial intervention. We have heard evidence from the college of GPs, the AMA and other presenters over the course of this inquiry that the six-minute-medicine approach is not necessarily that conducive to managing people with even mild mental illnesses. Is that something the Productivity Commission has given consideration to and made any recommendations in relation to?

**Dr King:** Yes, we did. During our consultations and in our report, it was very much in line with the assumptions (inaudible) GPs often find it very difficult to operate within the short-term Medicare funding arrangements that currently exist. While many of our GPs do an excellent job, many of them are not mental health experts. We heard from GPs that they felt they needed more assistance. We think that assistance can be provided through technological solutions. Technology can increase access to GPs, psychiatrists and psychologists and to what is called supported online treatment. We have all—certainly here in Melbourne—become more familiar with that technology over the past couple of years. It is also the case that GPs need assistance with the diagnosis and knowing what the referral pathways are for people with mental health issues.

A recommendation around that was to have developed a digital platform that would be available for GPs to assist them both in diagnosis and in referral to services. Our basic model for that was the PORTS scheme which at that stage was running in Western Australia. I suggest it would be a good idea for the committee, if you have time, to get a bit of background information on PORTS. It seemed to work very well, had been evaluated and was quite successful. It was that digital assistance, if I can put it that way, for both GPs and people who simply wanted to have questions answered about their mental health. Maybe they are feeling a bit of anxiety. They may not be feeling quite right and want a reliable online tool that they can go to rather than trying to find out from `Dr Google'.

**Ms KING:** Dr King, we have heard suggestions, particularly throughout today's hearings but on previous occasions as well, that there should be a legislative or bureaucratically required framework for joint service planning—that suggestion has come through quite strongly on multiple occasions—to avoid overlap, maximise efficiencies and ensure that people, whoever they are and whichever door they are walking through, get the services they need. I want to reflect specifically on workforce. Many of the challenges that we are seeing across our mental health system are going to be difficult to address without an increasing and decentralised workforce. Are you also suggesting that a joint workforce planning model should be required of various levels of government? Is that something that you recommend? I would love to hear your thoughts generally about joint workforce planning.

**Dr King:** From memory, we do not have a specific recommendation on that, but we are very strong in our recommendation on joint service planning and the need to make sure that workforce issues are dealt with under that joint planning, essentially under that whole-of-government national mental health strategy. There are a range of issues with workforce that we deal with specifically in the report. For example, we have some recommendations around the training and the numbers of mental health nurses, the potential for better use of peer workers and the shortage of psychiatrists in clinical practice.

In our report we find that we are unlikely to fill all the gaps simply by focusing on traditional workforce, if I can put it that way. You can train more psychiatrists, let us say, but the leafy suburbs of Brisbane tend to be a lot more attractive than some other parts of Australia. We found when we went to rural and regional areas in particular that there were simply shortages even of, for example, psychologists. Where we did not find a particular shortage in Australia, we found that there were very significant shortages once you get outside essentially Melbourne, Sydney and Brisbane. We need to make sure that we have access to the relevant workforce. Telehealth, which has been used in the past couple of years, is evidence based and appears to have been successful during the COVID pandemic, and we recommend that that continue. It is my understanding that it still has a deadline, if we can put it that way, from the federal government's perspective for Medicare funding. We also feel that more use of supported online services, particularly for the large group of people who have mild anxiety, mild depression, would mean that they may get well without formal clinical intervention but will get well faster and get better sooner if they receive some support. That support can be through moderated online services, not necessarily face to face. MindSpot is one example.

**CHAIR:** I think the member for Moggill and I would furiously agree with the sentiments about the joys of living in the leafy suburbs of Brisbane, but I am not sure the rest of the committee would jump on board with that!

**Dr ROWAN:** It has been suggested by some key stakeholders in Queensland that the Queensland system needs an additional 500 new beds and 250 refurbished beds. You might have to take this on notice, but I do not know if there is any work the Productivity Commission could provide as to whether that is an accurate reflection and how that is determined.

Secondly, it has also been raised at times that within our adult mental health units there are classified forensic mental health patients or patients with intellectual disability who have comorbid mental health conditions and that they are not best placed to be looked after in those acute mental health units in our public hospital system but there might be more appropriate facilities. I wanted to get comment about the care of those particular groups and about some of the suggestions around bed numbers in Queensland, knowing that beds are not the be-all and end-all but certainly we need beds at that pointy end of the mental healthcare system.

**Dr King:** We do not have specific recommendations on new beds or bed numbers in Queensland, but we do have a fantastic mental health service planning framework which would answer that question. Professor Whiteford is the expert on that framework, so I will pass it over to Professor Whiteford.

**Prof. Whiteford:** The service planning framework, just for the member's quick understanding, takes the resources needed over a 12-month period in early intervention, primary care, specialist care right through to hospital beds for a designated population which can be adjusted based on mortality

or if there is an Indigenous community within that setting or by age. In the 155 care profiles in the model, it assumes, if you have the balance right, how many beds would you need. The reason the pressure is so high on beds is partly because the bed numbers are lower in Queensland than they should be and partly because the other services that should be available prior to going into an acute hospital bed also are not available.

In the model the Productivity Commission did, the subacute beds were much more undersupplied than the acute beds. If you do not have a subacute bed, someone will get admitted earlier and they will stay longer because there is no step-down service for them to go to or they will be discharged prematurely, their condition will relapse and they will be readmitted. The number of beds is not just an absolute number; it is a number dependent upon what other services are available in the continuum from early intervention, primary care, specialist care in the community right through to the bed based services.

Based on that, the answer to your question would be that the service planning framework has been used by the Queensland government to model that. Yes, the beds are in short supply but they are not in as short supply as they would be if we had everything else in place in the community which we do not have in Queensland.

**Mr O'ROURKE:** My question is in regard to workforce, particularly in regional and remote Queensland—away from the leafy Brisbane suburbs. It is more a question around Medicare rebates. Are there different payment levels in regional Australia than in the south-east corner? Also, for some university degrees if you go west you get a credit back on your university costs. Is that across all of the health services?

**Prof. Whiteford:** I do not know whether that is across all of the healthcare providers. Certainly it is in the major health professions where you can have differential bonuses or rebates to relocate to certain areas and remuneration can be adjusted. Remuneration is one thing, but it seems to me that there are other things we could do to better support rural and regional practitioners. The use of telehealth and telepsychiatry is a way that we can do that.

There are a lot of support services that are not strictly medical but are quite important in rural communities. Rural communities in my experience tend to be resilient communities, but there are issues there that sometimes significantly impact—I am thinking of stigma, for example—in a community. Mental health, despite everything we have done over a long time, still often carries a stigma. That can result in people delaying treatment. It can result in people not wanting workplace colleagues or even extended family to know that they are struggling until it is too late or later than it should be. There are a range of things around the supply of workforce but also around other things we can do in communities to make it easier to get service there and help people.

The last thing I will say about workforce planning—if, for example, you are using that service planning framework that has been mentioned and Dr King just mentioned—is that across the 155 care profiles there is modelling which has been done—in fact, the federal government has asked for—to look at what the workforce would need to be to deliver the services at the level that is recommended. Given how long it takes to train psychologists, psychiatrists and nurses, we need to start training them now if we need to have them in five, 10 or 15 years time. If you do the modelling for the workforce side of things, you can plan for what you are going to be providing in 10 or 15 years time. That is really important even though you cannot fix the urgent problems now and something will have to be done. You need to make sure those problems do not exist so much in 10 or 15 years time, and the tools to do that are available to governments.

**Ms KING:** I would love to hear your comments on scope of practice changes, particularly for our nurses and for our allied health practitioners, that might assist to address some of these workforce and workforce planning challenges. Is that one of the pathways forward to improve these matters?

**Prof. Whiteford:** The answer is yes, of course. The advantage of mental health is that it is not, in a sense, mainly a procedural type of medicine. The core component is an interaction between a trained health professional and a consumer or a carer or a patient. There are a range of substitutions across that. The key is around serious mental illness, where it gets more difficult, where there has to be clear diagnosis often of physical comorbidity. Medication is needed. Investigations are needed. For the majority of people with a mental health problem, the treatment is provided in primary care and it can be provided by a range of primary care providers. It can be provided by peer workers. It can be provided by telephone. It can be provided by, as Dr King said, an online computerised program backed up by a psychologist. The PORTS program in Western Australia is being run out of Macquarie University in Sydney and in Perth. It is working with GPs throughout regional and rural Western Australia. As Dr King said, it seems to be quite effective. There are ways to spread that workforce

and also to have scope of practice readjusted in a safe way and in an evaluated way. The evidence seems to be that we can do scope-of-practice changes to help fill in the gap where we do not have the clinicians where we need them.

**Mrs McMAHON:** There are a range of professionals and skills being employed within the mental health space. Could you comment on whether there is a hierarchy of treatment—the role of counsellors versus social workers versus psychologists versus psychiatrists, where it may be more applicable for those who seek to be treated by a psychologist to be treated by a counsellor—and how do we work between those different practitioners who are potentially territorial in their scope of work? Without causing argy-bargy between occupations, how do we as a government employ the right people at the right time and in the right place without stepping on too many professional toes?

**Prof. Whiteford:** You will have divisions between a scope of practice driven by history and a scope of practice driven by things that can only be done by certain types of practitioners in their training. A lot of the early intervention or a lot of the mild intervention at the primary care level does not require a medical practitioner, although a medical practitioner needs to be available. I will say that for people who have had a past history of significant trauma or who have had a range of comorbidities or vulnerabilities, even though their condition might be early on that trajectory of intervention, some of the early intervention would require specialist teams. Early psychosis would be an example. By and large, for the majority we do have a continuum of need and we have a continuum of cost in expertise of the response given.

How do we overcome the traditional way it is allocated? A lot of that is about educating the consumer. There are people who will go to MindSpot, which is an online program, because even though they might be someone who would normally see a psychiatrist they say, 'This is what works for me.' Others say, 'I don't want to talk to a robot. I want to talk to the best possible professional I can,' without knowing that someone else could provide just as good if not better help for that individual. Public education and making consumers aware of what is available and where they can get the quickest help at the best time that works for them is something that I think would help better distribute the resources that we have across the need that exists.

**Ms CAMM:** My question is in the same vein. I think it is the federal government that made a decision to not fund to the same standard social science degrees and the like. There has been a focus both at the federal and at a state level on STEM—science, technology, engineering and mathematics. When you were looking at workforce planning, did the Productivity Commission find some of those softer tertiary degrees like social work et cetera? My concern is that there is a suite of services and allied health professional services that are required in workforce planning. Is the focus now just on the frontline clinical services? Are the structures around university placements and around government incentives et cetera focused at the pointy end rather than this continuum of a workforce, whether it be social work, counsellors et cetera? Did you find any evidence of that in your work?

**Dr King:** The answer is yes. We found issues with the current mix and the current way that the workforce is trained. For example, in addition to stigma that Harvey mentioned earlier, there are issues with the level of training or where mental health training comes into a curriculum. Let me give you two very quick examples. The first is mental health nurses. That has gone from being a dedicated undergraduate degree to being a bit of an add-on at the postgraduate level. What that means is that there are fewer mental health nurses, not surprisingly. We also heard examples of young nursing graduates who are thinking of going on and doing a mental health specialisation essentially being talked out of it because of the view that working in mental health is not quite at the same level as working in physical health care. I think we need to get over that stigma as part of our workforce planning. If we have a workforce that is stigmatising mental health issues, we are in some trouble.

The other example is that I want to make sure we do not forget that at the low-intensity end are the GPs. The GPs are the main gateway for people who have mild anxiety and depression. They make up more than a million Australians each year. The GPs may refer on to a psychiatrist or a psychologist or even a social worker under MBS or face-to-face therapy, but often the GPs engage in the face-to-face therapy themselves. We need the make sure that our GPs have the training if they are offering that face-to-face therapy. GPs are also under pressure sometimes to prescribe. We do have concerns noted in our report about the level of antidepressant prescribing in Australia. Until we make sure that GPs have the resources they need to be able to provide the best advice to someone with mental health issues who comes through their door, we are really going to leave a gap in the system.

**CHAIR:** Dr King, I have an economic question of some description. If we are wanting to shift some of the resources we are currently putting into acute services for the people who are chronically ill and put more resources into the early intervention and prevention space, the outcomes are often

hard to track. They are not linear outcomes. It is not like an orthopaedic ward, where you give them more money and they do more hip replacements and you can see the outcomes. How do we measure accountability in this area and track progress?

**Dr King:** That is a great question. It is very hard to do. We have to make sure that we look over time and over a broad population to get the data on whether the early intervention and prevention programs are working. Unfortunately, there is too little evaluation in this space. Often programs are started and then stopped without the relevant data being collected or being evaluated as to whether the program was successful or not.

There are some international studies and Australian studies where they have evaluated programs. We tried to put as much of that together as possible in our report so that we could at least evaluate the potential benefits of groups of interventions—for example, individual placement and support, which is an employment initiative; telehealth; or suicide prevention, for example, making sure there is follow-up when somebody who has attempted suicide is discharged from the hospital or community medical clinic. For some of these the evidence is quite clear. We can save lives. We can improve the quality of life. We can have an economic gain. We can save not simply money overall but in some cases we can save government money, although sometimes some level of government spending can be another level of government saving.

There is evidence there. We need to gather more evidence to work out what works. The available evidence is that if we get the early intervention and prevention programs right we can make a big difference to the way our health system performs. We can keep people out of ED. We can keep people out of hospital beds, which are the most expensive place for them; we can keep people living in community, which is where they want to be, and we can end up with a better health system.

**CHAIR:** It is not that dissimilar to population health measures in the physical realm. I recall when we started the Slip, Slop, Slap ads. We now have a lower melanoma rate in Queensland, but you would not have picked that up in the first two years or even the first five years or 10 years. We talked earlier about joint planning and co-commissioning of services. Are there any other jurisdictions that are rolling that out and rolling it out effectively? I know that Victoria has talked about it.

**Dr King:** I cannot think of any off the top of my head. The co-commissioning inevitably depends on the federal government and the relevant state government working together. Professor Whiteford may have some more up-to-date information than I have. When we did our report there were pockets of excellence, if I can put it that way. They were often dependent on particular individuals at a local level. Professor Whiteford might remember when we walked into a meeting in Wagga Wagga where the local hospital district and the PHN were literally operating side by side and chairing meetings and working fantastically together. There are pockets of excellence and coordination. Does the system in any state allow that sort of excellence statewide? Certainly when we did our inquiry the answer was no, although things may have changed since then.

**Prof. Whiteford:** There have been examples in Queensland. In Metro North, despite the challenges they face, the PHN and Metro North HHS do have a national reputation for doing well together with their joint regional planning. The issue is bringing in some of those other agencies we talked about which are not primarily health but are really important in health outcomes for some people—Education, Housing, Police, first responders, Corrective Services, and law and order. Those sorts of services need to be involved at times in the plan. Increasingly that is happening but it is taking cultural change amongst the providers to be able to do that.

**Mrs McMAHON:** You would probably not be surprised that none of the submitters, whether they be government departments or NGOs, have asked for less money in order to deal with this issue. Everyone acknowledges that more funding is required and it is needed now. We understand the benefits of investing early and how much money that can save governments and society in the long run. Notwithstanding that, money has to be stumped up now.

There are obviously a number of financial levers that government can pull. I understand that it requires investment from both state and federal government to get the funding models right. We heard today that in Victoria a levy was applied to get an instant boost of funding into mental health. Does the Productivity Commission have any insights or recommendations or thoughts on those funding levers, either at state or federal level, that are going to help us generate the types of dollars needed that people are talking about to address the issue?

**Dr King:** I am familiar with the Victorian levy. We did not go down that route or even into that specific detail. Really, it is for the state and federal governments to coordinate and lead to be able to make sure that it is clear who is paying for what and who is responsible for what. Unfortunately, there did appear to be some reluctance, if I can put it that way, sometimes to take that responsibility at certain levels of government.

Our main recommendation was a national mental health strategy, and a key element of that was funding. As Professor Whiteford said, it is funding both across the layers of government and between the different areas of government. You need to have Housing at the table, you need to have Education at the table, as well as having federal Health and state Health at the table.

I understand why Victoria has gone down that route of a levy. My concern, and one of the reasons the Productivity Commission did not go down that route, is that without having that cross-government coordination I am not sure we are ever really going to end up in the space we should be in mental health.

**Dr ROWAN:** If I look at the National Mental Health Service Planning Framework—I am using rough figures here—it looks like we probably need a 50 per cent increase in community staffing. Many of the models that exist are based on a five-day-a-week model as opposed to being accessible for seven days a week. What I mean by that is the community mental health teams responsible for the needs of consumers and patients. Has the Productivity Commission done any work around state based industrial relations frameworks and what needs to happen to drive innovation and flexibility in relation to workforce in the public sector to meet the needs of consumers in a much more modern, responsive way with respect to mental health systems across Australia?

**Prof. Whiteford:** While Dr King is having a think about that, if there is one figure that as a state parliament you should look at in the Productivity Commission report, which is a massive report, I would advise and encourage and suggest that you or the people assisting you pull out figure 12.12 on page 572 of the Productivity Commission report. That looks at the amount of time an average FTE employee—whether that be a psychologist, nurse or doctor—in state government community mental health services spends on patient related activities. It is 30 per cent across Australia. Is that true? The AIHW produce the data and the Productivity Commission team assemble the data. The service planning framework estimates, based on expert opinion, that it should be 67 per cent. In the private sector it is 85 per cent. There are things we need to do with our existing services now which in theory could double the amount of patient related activity that those services are doing.

When I talked about this appearing in the Productivity Commission report my colleagues said, 'What's going on here? Do you really think it is that low? There is a lot of paperwork we have to do.' What they were telling me is that they have become so risk averse that it has become too much about pulling out the forms and ticking the boxes so that they can be seen to cover and do the right things. That has resulted in less time being spent with the patient, with their family, talking to the GP and talking to the social support networks where that is necessary.

I do not want to say they are not working hard, because they are holding things together—they really are. We need to do better in thinking about how we can reward flexibility and reward increased productivity and output amongst those teams in the volume of work they are allowed to do and measure that better. I think we are not getting the return on the existing investment in those services.

If you put more money down the same pipelines that you have now, you will get more of the same outcomes. You are buying more of the same outcomes. What Dr King said was absolutely spot on. You have to change the structure that you are going to put new money down to get better value for the existing money and so the new money buys more of what you want.

**Dr King:** Professor Whiteford took you to exactly the same diagram as I was going to but I was trying to remember where it was. There can be arguments about what is the optimal amount of time that you spend face to face with a consumer on consumer related activities and on other activities. The data we were able to put together in that chart is pretty stark by any measure. Have a look at the numbers on figure 12.12. It is pretty hard to say that any jurisdiction in Australia is anywhere near what you would hope to be optimal.

**CHAIR:** Dr King and Professor Whiteford, thank you for your time today. We have no further questions. Your evidence here today has been extremely helpful to the committee. We have been relying on the Productivity Commission report as we have moved through this inquiry and no doubt we will continue to do so. We hope we can take some of the good work that you have done and make recommendations for it to be applied in a Queensland context.

**Dr King:** Thank you very much.

**CHAIR:** With the agreement of the committee, I would like to recall Professor McGorry and Commissioner Frkovic to give members the opportunity to ask additional questions.

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

## McGORRY, Professor Pat, AO, Executive, Orygen

**CHAIR:** Professor McGorry, your submission on page 8 notes some new international trials of diversion options for youth offenders. Can you provide more details on these trials and programs?

**Prof. McGorry:** Our clinical director, Professor Andrew Chanen, is probably the best person to give you the details of that. We could take that on notice and get back to you. I can say a couple of things. The age crime curve for offending is almost the same as the incidence curve for mental illness—in other words, puberty, surging through the teens and early twenties, and then dropping off after 25. That is not a coincidence, I do not think. What we see is that a lot of the risk factors for mental illness the committee was exploring earlier are the same risk factors that cause offending behaviour, particularly in young men, and there are very high rates.

You have already heard in other submissions and evidence about the very high psychiatric morbidity in the population of young offenders, yet nowhere in Australia, to my knowledge, is there really an effective youth forensic mental health service. The adult forensic mental health services are variably effective, but in relation to the youth ones I am not sure about Queensland. I heard that it is better in Queensland, but that is a huge opportunity to prevent recidivism and a longer term offending career. It is one of the ways that the Productivity Commission documented you can save money. You do not have to incarcerate large numbers of young people if you provide the right sort of mental health and other types of support for them. That is a very big opportunity.

I would just comment on Stephen King's response to you about early intervention. The one thing they did not actually look at is the best evidence base for documenting the return on investment for intervention, which is early intervention for psychosis. That was the original work that I did in the 1990s in Melbourne. There are hundreds and hundreds of these early intervention services for psychosis around the world. The return on investment is up to 17 to one, and the forensic consequences of just one of those contributors is that you get the return on investment in the first year. You do not have to wait three, five or 10 years to see it. That was a big blind spot in what they did. They did not actually nail that one, to be honest.

**CHAIR:** Is psychosis a condition that occurs in the age group we are looking at here?

**Prof. McGorry:** Yes, par excellence. The original term for schizophrenia, which is the main diagnostic group there, was dementia praecox, meaning dementia occurring in young people. It is not dementia; it is a treatable, reversible condition. That is the best evidence of all because that is the most severe condition that appears in that age group, yet it is very responsive to early intervention and better outcomes. You save heaps of money. You do not even have to find new money; you just have to spend money differently.

**CHAIR:** That is specifically for psychosis you are talking about, but not schizophrenia?

**Prof. McGorry:** Schizophrenia is a subset of psychosis. It would apply for anorexia; it would apply for any treatable condition in that age group. That is what we have moved to more recently.

**CHAIR:** In your opening statement you talked about the work of the Victorian royal commission and bringing services up to where they should be now, but you seemed to indicate that there was not a lot done around the missing middle that people keep talking about. What are your views on how we move to address that missing middle?

**Prof. McGorry:** If you refer back to Ivan's evidence, he really made that very clear. There are three tiers and they are arbitrary divisions: mild, moderate and severe. You can put numbers on those. I think the Productivity Commission actually did do that. Traditionally, state governments are supposed to be responsible for the severe end, which is three per cent of the population; then there is another six per cent plus that are sort of moderate or moderate to severe; and then there is about 10 or 11 per cent that are mild. The federal government has traditionally been responsible for the mild bit, and you were discussing earlier what GPs should do and what they cannot do. That is what headspace is targeted at as well, that milder end. It works really well. Thirty-five per cent of the young people who come into the headspace system do really well, but the other 65 per cent are allowed in because there is primary care, but they do not do well because that next bit is missing. You can quantify that. Unfortunately, the moderate bit in particular and part of the severe bit, as Ivan pointed out, does not get access to care except in life-threatening situations when they turn up in the ED. That is why it is the joint responsibility of state and federal.

The state government has a fair bit of work to do to even cover the severe bit and maybe a little bit of the moderate bit. The federal government has to come up from primary care, which we are trying to encourage it to do. In six locations in Australia there are early psychosis platforms, including

one in South-East Queensland on the Gold Coast and Logan. There are six of these programs in the whole country, but they need to be everywhere as a solution to the missing middle and they need to be transdiagnostic. They need to include not only psychosis patients but also anorexia, borderline personality, complex mood and substance use. We have the model and the platform—Ivan talked about this—and we have convinced the federal government to start investing in that model too, the community hubs, the Head to Health hubs and the Poppy Centre/children's hubs. Everyone has agreed about the template or the blueprint but, just like Harvey and Stephen were saying, who is going to fund it? It is like a Mexican standoff.

**CHAIR:** Commissioner, do you want to add anything to that?

**Mr Frkovic:** Picking up on Professor McGorry's point, the federal government has taken a step in this with the new Head to Health. As I said in my statement, I think it is a very small step. A lot more is needed in that space. At the same time, the state government, with its state services, needs to lean into that so we provide that continuum rather than actually saying, 'This is another separate service in its own right.' That is what I am saying: we just have to try and bring that together. The step has been made; let's lean into it and let's grow this. Victoria has decided to fund 60 of these community centres across the state. They are leaning in quite a lot from the state perspective, but their advantage is that they are also taking advantage of 15 that were funded by the Commonwealth as part of the COVID recovery. You are talking about fairly large infrastructure that is being developed in the missing middle and bringing those two ends together.

**CHAIR:** Are these centres that you are referring to dealing with what we refer to as the treatable, reversible diseases like psychosis and eating disorders et cetera as well as the more broad anxiety issues that might develop into things if left unattended?

**Mr Frkovic:** That is my understanding.

**Prof. McGorry:** They would be doing that. They are sort of transdiagnostic. The other federal initiative that I mentioned, the early psychosis platforms, could also be another piece of that missing middle infrastructure, but they should also be broadened into other diagnosis. Young people have not read the textbooks: they have bits of several different disorders. They come in with some psychotic symptoms but they are depressed and they might have some eating disorder features as well, so it is much more fluid than you would get from picking up a DSM-5.

**Mr Frkovic:** What the Victorian model does is provide that new front door, which is away, as Pat and others have said, from acute inpatient and ED services, and that is what I think is a critical aspect of that. We have to make that work.

**Ms CAMM:** Earlier in the week we heard evidence around parts of Queensland in relation to that risk mitigation response. As you were just explaining, the Victorian government is taking advantage of the federal government. We had a discussion with Queensland Health this morning. In their submission they spoke about culture. In your experience or in your view, do you think that Queensland—and I just mean culturally, whether it be the workforce or policymakers et cetera—is at that same place to take advantage? I find it interesting, Professor McGorry, how you say it is a bit of a standoff. We talk a lot about collaboration, co-design et cetera, but we need the culture and leadership to achieve that outcome. Do you think that Victoria is just at a different point in time, whether that has evolved over their public health journey or their understanding of mental health, or is it because it is a centralised model? What do you think are contributing factors? Do you think that as a state Queensland is just at a different point in time? I would be interested to get the commissioner's view on that as well. There seems to be conflict in all of the evidence we are hearing. We all want to collaborate, yet it is not happening.

**Prof. McGorry:** Obviously the commissioner would be better placed to comment on Queensland. I would just make one comment to start off with, though: the national agreement has been progressed over the last 12 months or so. It is all very well for Stephen King to say, 'We're not going to recommend what should happen because the state and federal government should be mature and work things out.' I was blown away by that comment, I have to say. They had an opportunity to really say some important things. Their expertise is in economics, not health service design. Their first report was absolutely superb because it nailed the cost of underinvestment in mental health: $200 billion a year. Their expertise was very clear there; then they got into other stuff.

The agreement is still not signed. The Queensland government has not signed the agreement with the federal government or vice versa. You can see the difficulty. That is holding up money that has been allocated in the federal budget for waiting lists in headspace centres and other initiatives because they have not been able to agree about it. I have not been involved in those negotiations. I am not blaming anyone. I am just saying that it is a problem, state and federal. What Ivan is saying

is that both parties have to do what they can. It is like the Sydney Harbour Bridge being built in 1927: you build one span from the south bank and one span from the north bank and eventually it is going to meet in the middle, we hope, but you have to keep building from both ends. That is what we are talking about.

**Mr Frkovic:** I think there is a commitment and passion in mental health and leadership at the HHS level to work together. As I said earlier, I think it is about freeing up and providing flexibility in how that funding is used. When I was working on the establishment of the Queensland Mental Health Commission, before I became commissioner I spent six months working on establishing it so I was in a pretty unique position.

Going back to the earlier discussion we had about being risk averse, statewide we consulted thousands of people about this model. The staff in public mental health said very publicly, 'There is one thing the commission can do for us.' I will repeat those words. I heard this in Townsville and it captured the sentiment of that room: 'I hope you can liberate us to do our work.' That was a really powerful message that stayed with me all this time. How do we liberate people to do their work?

I think we do have a risk-averse system, which then does mean that our clinicians can only spend between 20 per cent and 30 per cent of their time seeing clients. I am not saying that we should be laissez-faire about our work, but I think there are certain things we could do very differently to get—as Harvey said very clearly—better efficiency from our existing investment but also give us an opportunity to invest in different ways to get different outcomes. If we invest into more of the same, how can we expect something different? I think there is leadership, there is passion and there is commitment, but we have to unpack that and stop that really extreme risk-averse culture but also give flexibility in how funds can be used so you can do local co-planning and co-commissioning and integrate service delivery. I think they are some of the keys that would help.

**Prof. McGorry:** It was really great that Harvey Whiteford did actually quote that figure from the Productivity Commission, because I see that in our service. I see our clinical staff spending 20 per cent or 30 per cent of their time seeing patients in the state funded bit, and then they go and work in our headspaces where it is fee for service and, like you said, they see maybe eight people a day where they see about two people a day in the state service because they are caught up with all this red tape and basically risk-averse behaviour. Also, I suppose there is lots of unnecessary bureaucracy and meetings which could all be cleaned out. To change it you cannot say, like you say, that they are not working hard enough. You have to incentivise them in a way to work differently and it needs culture reform. I am glad you brought that up.

**Ms KING:** Thank you both for returning. At the end of your earlier session we all had long lists of questions that we did not get a chance to ask. I note that I have learned something new, which is to reconsider what `early intervention services' means. They are not just at the mild end of the spectrum; they might be for very severe illnesses but just getting in earlier. Professor McGorry, I want to ask about the part of your submission that talks about co-designing services alongside First Nations people. Could you talk a bit more about that—what process might be looked at to do that and what kinds of services have come out the other end of that process where it has been embarked upon?

**Prof. McGorry:** On the first point that you raised, severe mental illness does not appear magically overnight. Every single person with a severe mental illness has gone through a mild stage and an earlier stage. We have a huge American grant from the National Institutes of Health in Washington to research and refine treatments for the very early stages of schizophrenia and psychosis. The people who are on the way to developing schizophrenia have had months or years of milder earlier symptoms. It is a bit like when you are developing a heart disease. You do not suddenly have a heart attack. You have warning signs, often for months ahead of that time, so you have an opportunity to prevent the illness getting more entrenched and severe. That is true of every case of serious mental illness.

Illnesses are not categorised permanently into mild, moderate and severe. You might have that impression from reading psychiatric stuff but it is just the same as any other illness. That is what early intervention really means: heading the illness off at the pass. We have introduced a staging model that has been taken up in many countries now where you define stage 1, stage 2, stage 3 of mental ill health, just like you do with cancer, and the treatment is different at each stage. This is a great way to think about early intervention.

Moving to your second point, I think there is more expertise in Queensland about co-designing Indigenous mental health services. I would not presume to comment much further about that. We have tried to develop that but it is still pretty early days for us.

**Ms KING:** In that case, Ivan, would you like to make some further comment about that?

**Mr Frkovic:** In terms of co-design, one of the great experiences that I have had with the government was when there was an allocation of funding to look at Indigenous youth suicide and we were able to present to the Treasurer at the time an argument that said, 'Let's not decide what that looks like in George Street or in Canberra. Let's look at that bucket as a bucket of money to work with those communities, for them to co-design and make some decisions and lead what is important for their communities.' I have to say that the government was in some ways really brave but really supportive of that approach. We are still rolling out that type of approach. The concept that you start off with is that, sitting in George Street, I will not know and will not be able to make a decision as to what is best, for example, in Cunnamulla, but in actual fact we are looking at youth suicide and how we then work with that community and they own it and they lead it et cetera.

Also, what a lot of Indigenous communities will tell you is, 'Don't come to us with just a blank sheet to basically help us deal, for example, with youth suicide. If we could have done it we would have done it already.' We can use some of the examples of things that have worked in other Indigenous communities, for example, linking with some communities and looking at what has worked in others. Co-design can be broader than just sitting down and working together. I think it starts at that more systemic level about where your funding comes from, the strings that are attached to it and then how you actually work with those communities.

In Queensland, to be fair, I think we have done that relatively well but I think we could do more of it from a social and emotional wellbeing perspective. We have heard some examples this morning. For example, in Townsville the maternity services from the HHS are now offered through the TAIHS in Townsville. That is a phenomenal way of doing business. There are some good ways for how we can co-design services that meet the needs of that particular cohort.

**Mr MOLHOEK:** You mentioned the Victorian model of community hubs. Could you give us a bit more detail on how they operate? Did you say there were 200?

**Mr Frkovic:** Sixty.

**Mr MOLHOEK:** And 15 were already—

**Prof. McGorry:** They have not started yet, by the way. This is the blueprint from the royal commission. The concept is a bit like the Head to Health hubs that the federal government is also trying to rollout. Although they have announced them, they have not really made an awful lot of progress, partly because of workforce again.

I think they thought that in some ways this was like a headspace equivalent for adults or for whole of lifespan. However, despite the poor distribution, there is a fair bit of infrastructure around the mild group in adults that sort of works. You have GPs and better access. Obviously with co-payments access is pretty variable for people who cannot afford the co-payments. That kind of model is there for adults.

The model was not there for young people, which is why we had to design and scale up headspace. Young people did not go to GPs, by and large, for mental health problems. It did not work for them. Headspace is like a version of primary care for young people, but it is multidisciplinary all the same. It is complementary too. GPs can refer into headspace too. That is the primary care system for young people: headspace plus GPs.

The adults have GPs and better access anyway. The hubs were meant to be the next thing, the backup system, for GPs. They were also meant to be accessible just for walk-ins. It is a little blurred if you are trying to pigeonhole it as primary or secondary type care. They have a bit of a hybrid function, the adult ones.

**Mr MOLHOEK:** They would be an adult version of headspace, so to speak?

**Prof. McGorry:** In part, but they are much better resourced. They have millions of dollars per centre rather than headspace, which only has a few hundred thousand dollars per centre. The financial model of headspace is fragile. It is losing workforce at the moment because the practitioners can get a better deal working somewhere else.

**Mr Frkovic:** Having run the headspaces myself, I can certainly tell you that it is really tough because it is a private model with some block support funding. It should be the other way around. It should be a block funded model backed up by private practice.

**Prof. McGorry:** Yes, enriched by private practice.

**Mr Frkovic:** Yes, enriched by private practice. But going to the adults, if the committee is going regional, as I think the chair said, if you are going to Townsville one of the new Head to Health centres has been established. Picking up on what Pat said, at least from my early impression—it only opened two weeks ago so really we are still waiting. I do not see the public mental health system leaning into

that. There still seems to be a separation. I am not sure how well it is linked to broader primary health care. I need to see it myself as well and I have not yet, even though I was involved in some of the early design of it and I was part of the group. There is one in Queensland that was funded a couple of budgets ago and that has finally got off the ground.

**Mr MOLHOEK:** Is that Townsville?

**Mr Frkovic:** Yes, Townsville. These things were meant to be the place where people are not excluded. You might have a severe mental illness and that is where your point of access could be, but then you are channelled into the public system if that is what you need, depending on your level of severity. Unless the public mental health system leans into that service, there will be a gap between the two. If you come there and you can actually have your needs met by the primary healthcare system, you can be channelled there. Also, you can provide treatment and interventions and a holding opportunity for people in the centre itself if you get this right. It is meant to be that joining bit, which is what the Victorians have talked about. As I said, I have not seen it yet in Townsville and I have to say it is early, so I do not want to make any value judgements.

**CHAIR:** Is the PHN that covers Townsville on the same boundaries as the HHS that covers Townsville?

**Mr Frkovic:** No. North Queensland is a real complex one. North Queensland, from Mackay all the way to the Torres, is one PHN and three HHSs.

**Mr MOLHOEK:** It is a very big area, isn't it?

**Mr Frkovic:** Just a small catchment area!

**Mr MOLHOEK:** Professor, you touched on the productivity of mental health carers in terms of the number of appointments and face-to-face clients they can see in a day. Progressing any real change would require significant industrial relations reform as well, wouldn't it?

**Prof. McGorry:** Yes, and that is a very good point. The way they allocate the workload to the people in the service is by case loads, by case numbers. We have this crude way of working out how much work should be given to each one of those people, whether they are case managers or psychiatrists or doctors. It does not make any sense as the case load is irrelevant because there are other variables, like the complexity of the case load and also how frequently you are seeing the person.

I work one day clinically a week, across the week. It is the equivalent of one day a week clinically seeing patients. I have 40 patients on my case load. The case manager has 20 patients on their case load. I do not see those patients as often as they would be seeing those patients, but I spend probably as much time in face-to-face care in a week, even though I have lots of other roles, as the full-time clinical case managers do. That is reinforcing what you just heard on the percentage of time that is spent face to face. I would spend 20 per cent of my time, but it only takes me one a day week to do it and I have four other days doing other things.

What are they doing with the rest of their time? I think Ivan is right: they would be very happy to free themselves up from a lot of that other stuff. Because the system has been so underfunded, the whole purpose of all these risk management and safety type things—which sound appropriate, don't they? They sound appropriate: safety in clinical standards and all that sort of thing. But they are purely designed to avoid the hospital system ending up in the court for medical-legal reasons. That is the main purpose of those things at the moment, sad to say.

**Mr MOLHOEK:** To declare an interest, Chair, I am a director of Bravehearts. One of the challenges that we review every month in our monthly board meetings is the number of clients being seen by our counselling and support teams. Could you comment on the other aspect of that, which is simply the number of no-shows? The challenge we have is that our teams work to the, I think, social services award or the special award for people in not-for-profit social service organisations. Often they will make the 16 appointments or whatever the permitted amount is for the week, but they will see only about 70 per cent of those. It is exacerbated by the fact that a lot of people with trauma or mental health issues just do not turn up.

**Prof. McGorry:** It has to be flexible for those, recognising the client group that you are dealing with. You have to be prepared to jump in the car and go to see them. Flexibility about the way that you work is incredibly important. I think it is also not persecuting the staff because, like Harvey said, they are working really hard; they are just doing the wrong things because no-one has looked at their work practice for years and it would have to be negotiated with industrial. There has to be a win-win here because it is very dissatisfying working in that defensive medical-legal type way. The people are dedicated. They want to help people, don't they, Ivan?

**Mr Frkovic:** Yes.

**Prof. McGorry:** They are not the problem. It is the way the system has evolved. It has become reinstitutionalised in a different way. We got out of the mental hospitals 25 years ago and we have ended up in a new system that gradually, like the Amazon jungle, has started to grow across and institutionalise everybody again in a very unproductive way. As well as money, which we have been talking about a lot, reform of the culture and the work practices is really important.

**CHAIR:** It sounds like we need an Indiana Jones to go in and cut a few vines. On that point, we might bring it to a close because we are getting close to time. Thank you once again, Professor McGorry, for making yourself available. Commissioner Frkovic, we going to have get you a frequent flyer number. You are always welcome.

**Proceedings suspended from 3.14 pm to 3.29 pm.**

**GEE, Ms Christine, Chief Executive Officer, Toowong Private Hospital**

**MORTIMER, Ms Anne, Director, Ramsay Mental Health Australia**

**WILLIAMS, Ms Mary, Chief Executive Officer and Director of Clinical Services, Belmont Private Hospital (via videoconference)**

**CHAIR:** Welcome. I would like to invite each of you, if you would like, to make a brief opening statement.

**Ms Mortimer:** Thank you. I would like to open by saying it is great to be here and to be part of the conversation. I think the private sector has a lot to offer in solving some of the issues for the delivery of mental health. It is a particularly exciting time at the moment in some of the other states where Ramsay Mental Health is as we have moved into collaborative models of care with government and trialling these and hoping that through that collaboration we are going to be able to extend the reach to all Australians, but particularly those states that we are in, and to do innovation around workforce so that we can join forces, if you like, and get the care and treatment that is needed out there into the population. We feel that for a long time working in silos has not always been to the best benefit of the patient but actually joining forces would be a good thing, and I think now more than ever with this huge epidemic of mental health it is really time to come together. We have a few models that we can talk about today that we are currently engaging in with state government and I think it is going to have some very interesting outcomes.

**CHAIR:** Thank you.

**Ms Gee:** I would echo what Anne has said in that it is very good to be here and to be part of the conversation. Toowong Private Hospital is a long-established psychiatric facility here in Brisbane. We opened back in May 1976. We have 58 inpatient beds and a comprehensive suite of day programs, which include a number of programs specialised and targeted at military service. We do a lot of post-traumatic stress disorder work and military trauma and related disorders. We also have quite a comprehensive community based Hospital in the Home program and partner with a PHN funded community organisation to provide mental health services into the community.

In terms of the overall picture in Queensland, there are 18 private hospitals that have 963 beds in total. That is made up of standalone psychiatric hospitals—there are seven of those—with 601 beds and also 11 private hospitals which have specialised units or services which contribute another 362 beds. In terms of funding for the private hospital sector, 83 per cent of the separations that we deliver are funded by private health insurance and the others are made up by people who fund themselves, WorkCover or private sources like that.

One of the things that has been very good for the private psychiatric sector is the reforms in March 2018 that allow people to upgrade their private health insurance so that they can obtain immediate access to psychiatric care. That is something that was lacking beforehand, where people would have to wait a period of two months. It has been a great thing for people to be able to access private psychiatric care when they find themselves short on cover or they realise that their policy is slightly out of date and they do not have that cover.

In terms of how important the private hospital sector is to mental health overall, nationally the private sector provides 38.8 per cent of all acute specialist mental health beds, and that is around 45 per cent of acute adult beds. That excludes services for a specific purpose, so eating disorder units, for example. The diagnostic groups that the private sector services are essentially the same as those serviced in the public sector but probably a little bit of a different skew. Certainly we do see schizophrenia, schizoaffective and other psychotic disorders. In the public sector that would be a higher percentage. In the private sector it is about 6.2 per cent of our services. In terms of where the bulk of the services are provided for in private mental health, it is major affective and other mood disorders. We provide 48.6 per cent of those.

There is sometimes a perception that the private sector treats the worried well. I have been in private psychiatric hospitals now for 25 years and I think it started back 25 years ago and still continues today. One of the things the private hospitals have been very good at over the past 20 years is collecting quite a suite of data through the Private Psychiatric Hospitals Data Reporting and Analysis Service. We capture for all of the hospitals in the country, including all of those in Queensland, a range of outcome measures, from clinician rated outcome measures to consumer rated outcome measures and also patient perception of care measures. Looking at the MHQ-14 measure, which is the measure that the consumer would give themselves, the total score patient

responses to admissions to overnight services put them at the lowest fifth percentile of the general population. That is an indication that we actually treat quite severely mentally unwell patients with high levels of anxiety and depressed mood and a lot of our patients do come in expressing suicidality.

In terms of what consumers and carers want, I would point to the Lived Experience Australia Missing Middle report. They certainly tell us that they want to have the availability of a range of services, both overnight and day patients; a calm and supportive environment; trust and to feel safe and not feel judged and stigmatised; the ability to be self-directed in their care; to feel listened to, having a say in their discharge planning and a time frame for that discharge; obviously quality and well-trained staff; and access to care when it is needed.

The services provided in private psychiatric hospitals are specialist led. For all of the psychiatric hospitals in Queensland, the admissions would come through private psychiatrists. To give you an indication, Toowong, as I said, is a 58-bed mental health facility. We actually have 72 credentialed private psychiatrists who admit to the service, whether that be to the inpatient unit or to the day programs or community based services.

The breadth of services we provide, as Anne alluded to, gives us the ability to really contribute to the training of a specialist mental health workforce. Certainly a number of the hospitals across Australia and across Queensland have training positions across nursing, medical and allied health. A number of us also provide senior registrar positions for the final year of training of private psychiatrists. They are in a variety of areas, whether they are general psychiatric care or specialised in military and veterans health or eating disorders and the like.

In terms of what is holding the sector back from being able to contribute more, it is really the siloed approach. Private hospitals are heavily dependent on contractual arrangements with private health insurers. That is one of the things that I think is a thorn in the side of mental health consumers themselves. The services that I provide because of my contractual arrangements are not necessarily the same services that Anne can provide or that Mary can provide. Within Brisbane you have three hospitals, but all of us are not able to provide a like-for-like service down to the different arrangements with private health insurers.

In terms of assets and opportunities, we really are able to work with consumers through relationships of trust and respect. We employ a skilled multidisciplinary team of mental health professionals and can certainly contribute a lot more to the training of mental health professionals in Queensland and nationally. We also are able to provide students and trainees with a very positive introduction into mental health, exposure to high-prevalence conditions and contemporary mental health team based working environments. I think we really have a lot to offer. We would very much like to collaborate with community based providers and provide more community based services, which is something that is precluded at the moment through health insurance. Very much, I think, if COVID has taught us nothing, it has definitely taught us that there need to be partnerships between public and private hospitals. That has been one of the benefits. Thank you.

**Ms Williams:** First of all, I would like to echo the sentiments of my private colleagues. I think Chris has summed up a lot of what I was going to say. I will just tell you a little bit about Belmont Private Hospital. We are owned under the Aurora Healthcare Group, which is the largest specialty private hospital group. We officially opened here in Belmont in 1973. We are the largest provider of acute private mental health services in Queensland. We are currently going through a rebuild and we will have 35 more beds by mid this year. We will have 185 acute mental health beds.

We are an authorised mental health service. We have a special care unit, so we take very high acuity patients in that special care unit. We have a number of specialty groups here. We have a 79- bed acute adult admissions unit; we have 35 beds in the older persons unit. We are adding 10 beds to that in the new build. We have a perinatal disorders unit, which is currently 10 beds and expanding to 14, and we are adding a 10-bed women's unit to that as well so we have the capacity to expand to 24 perinatal beds, which I believe are very needed. That unit has been in existence now for 30 years.

We also have a trauma and dissociation unit, which has also been in existence for 25 years, and we treat a number of patients with complex trauma and dissociative identity disorders. We actually have a temporary young adult unit. We are building a new one that is starting in July, but because of the demand for young adults in the private mental health sector we have established beds. At the moment we are admitting 16 (inaudible). I think that is a really important addition in the private mental health sector for treatment of young adults. We have a very busy neurostimulation unit here—TMS and ECT—and we have a very strong program based unit. We run 50 day programs and we attract roughly about 400 day patients to these programs a week: DBT, LCT, REACH. CBT, quite a number of very well (inaudible) standard allied health staff.

A lot of what Chris is saying I agree with. We have a pipeline. We tend to believe in `grow your own' to ensure we have really excellent (inaudible). We have student nurses—roughly 40 to 50 student nurses coming through here a week. We currently have five registrars, and most of the registrars who work at Belmont go on to be private VMOs here. It is a really good way to grow your own.

I am really pleased to be here at the table talking about this because I agree we have so much to offer the mental health sector. I know, as Chris was saying—and I was going to say the same thing—we are often viewed as being a hospital that treats the worried well. We actually treat very acute people here. We currently have two public-private agreements with Metro South and West Moreton and that is working really well. We can take public patients as demand on their services grows. I think that is all I have to say.

**CHAIR:** Ms Gee, I wanted to learn more about your program where you are partnering with the PHN funded community health service. How do people get referred into that service? Is it a one-on-one or a group type setting or is it done in people's homes? What is the nature of the program?

**Ms Gee:** Essentially, all of the above. It is run under the PHN service. We work with Communify, and there are three hubs in the Brisbane north area. Patients are able to be identified through the Communify mental health hub. We provide the mental health nursing component. That can be on a group basis. There are a number of patients that our mental health nurses see in their home and provide feedback. We have been running a mental health service for probably around 15 years and have moved with each iteration. This one has been running for about two years under the PHN funding. It is a little bit different in that the programs beforehand have relied on the patient having a psychiatrist and being referred by a psychiatrist. Then it morphed into the patient being identified by a general practitioner, having a mental health diagnosis and then being referred. This program builds again on that and targets some of the homeless people in terms of getting them engaged in a mental health treatment plan. The first mental health professional they may see might be the mental health nurse and then we work backwards, if you like, to get them seen by a general practitioner and engaged in treatment, including medication.

As well as providing the mental health nursing component, we also provide a number of psychology based programs. They are group based programs. Through COVID it got really challenging, but we have managed to turn those into virtual programs where patients can go to Communify still and our psychologists come over the Zoom to provide them with targeted mindfulness DBT and CBT based programs.

**CHAIR:** You mentioned in your opening statement—and there was agreement, I could see, from the other two presenters here today—issues relating to the contractual arrangements with private insurers and the limitations they placed upon each of the organisations here today. Can you take us through what sorts of things they limit you in being able to do as organisations?

**Ms Gee:** In terms of the limitations, I guess it is an historical thing. You have a contract with a health insurer that might recognise four different day programs, for example. If you then try to add a day program, because they are a contractual arrangement you have to seek approval from the private health insurer and get those recognised as approved programs. That is dependent then upon the insurer deciding that there is a need for that program or a desire for them to increase the number of programs that you are able to offer.

From Toowong's point of view—and I would imagine that Mary and Anne would be the same—there have been very few new programs or services that have been able to be provided by private hospitals purely on the basis that that would expose the insurers to a wider range of expense. For example, whilst Belmont currently runs a DBT program, we have attempted to get funding to provide a DBT program at Toowong and have been knocked back by all of the health insurers. It is very unfair that in Queensland a mental health consumer has to understand enough about the system to know that the only place they can really go to get DBT is at Mary's hospital but not at mine. It would be the same for some of the programs that we are able to run that Anne's Ramsay hospitals or Mary's would not be able to run.

**CHAIR:** Ms Williams, you talked about the expansion of your youth program. We have heard of huge demand in the younger person cohort. I know from being out your way that there seems to be a lot of building going out there at Belmont at the moment, so I assume you are building something good and new out there.

**Ms Williams:** Yes.

**CHAIR:** For other organisations, is that an area that you are expanding into because there is huge demand for it, or are there again restrictions on what you can do in that space?

**Ms Williams:** There is a huge demand for it but there are restrictions. I agree with what Chris was saying: health insurers can be quite difficult to navigate in getting programs up and running. Consumer demands for certain therapies do not really dictate to the private health insurance what they should pay for, which is really disappointing. I spoke to Ivan Frkovic about two years ago when we were talking about the demand on the public health sector with young adults, and when we were planning on expanding we decided that we would put on a young adults unit. There are going to be limitations on it. We were privileged to go through the incredible Lavender unit a while back. It is the size of several football fields, and I said to my doctors, ‘We are going to have one the size of a one-lane bowling alley,’ so it will be limited as to what we can take in terms of acuity and treatment. It will be very much a program based unit, but I just (inaudible) treating the tip of the iceberg and probably not highest acuity young adults. I think in the (inaudible) sector, there is a great demand for this.

**CHAIR:** Ms Mortimer or Ms Gee?

**Ms Gee:** Youth mental health is particularly difficult because of all of the services that have to wrap around and be included—school based programs and those things. You really need to have a service that has an economy of scale to be able to make it a viable service, which is where you probably see the youth mental health services are provided—St Vincent’s run a very good one in New South Wales—where they can leverage off a public mental health service as well. I think there is a really great opportunity to have public and private work together so that you could make a viable private youth service that uses some of the existing infrastructure available from the public youth services. Otherwise we both end up with a school system and all of the other things that are not always viable for a relatively small service.

**Ms Mortimer:** I would agree with what Christine has said. We are forging ahead in this space. We have developed a model of care that is around the 36-bed mark which caters for eating disorders, adolescent and young adult as a collective service, and we are opening that in Melbourne. We have opened in Sydney and we are currently building a second site for 41 youth and adolescent beds. At New Farm we are expanding into youth and adolescent as well to complement the existing eating disorder service.

We can do it very well. We have a model that has been operating in Sydney for some time around adolescent services in-house schooling, but it is much better to have a collaboration. The model we are rolling out in south-west Sydney at the moment, which is funded by the state government, is a broader collaboration for those three services. Whilst there are some overnight beds in that service for really acute presentations, we are targeting the day services area which we hope will extend the support to the families and those children and keep them out of hospital, in the community, which is preferable for a young person, yet give them a longer term level of support through day services. That is being developed by the local LHD and Ramsay Health Care, so it is quite innovative. We are also using the resources in the community for supplementary support. Psychiatrists in the community stay involved, but they are also using the expertise of the private sector, which has greater knowledge in these disorders, especially eating disorders. The public sector is way behind the private sector in eating disorder management.

Community aftercare is also something that we are bolting on which is very essential to these groups. I think there is great scope for this particular area.

**CHAIR:** The Productivity Commission federally talked about the need for localised planning and co-commissioning of services, and they anticipated a model that involved the PHNs and HHSs. Would you feel that the PHNs represent your sector, or are you well outside their sphere of remit?

**Ms Gee:** We have been very lucky because we have had a very good and productive relationship with Brisbane North PHN that exists purely because we were running a mental health nurse incentive program that they had to fund for 12 months in the handover from the Commonwealth funding it directly, through them. I think when the PHN came to meet us at Toowong they were like, ‘We really wondered what a private hospital could do in this space.’ It was the usual, ‘Don’t you just treat the worried well?’ and, ‘Would you be interested in doing these things?’ I think through our process with them they have realised the benefits of engaging with a sector that really does have access to a huge workforce.

One of the downfalls of running targeted type programs through PHNs based solely in community centres is: for example, if you are trying to run a mental health nurse incentive program, it is funded for 12 months or two years at 1.5 mental health nurses. Those nurses have to come from somewhere. They are not going to leave the Toowong Private Hospital, where they have been

employed for the past 20 years and leave all of their entitlements behind—their clinical supervision, sick leave and all of those sorts of things—when they could end up in 18 months not having a job anymore.

The ability for a private hospital to partner with a PHN and provide that service is great for the service because they get more than a 1.5 mental health nurse. We backfill their sick leave and annual leave and things like that. It works very well for the hospital because we struggle to run our own mental health nursing services that are funded by the private health insurers because not all insurers fund them. I can employ six mental health nurses, knowing that there are a couple who will be working here, and you run a service that is viable across a number of funding sources.

**Dr ROWAN:** Thank you for the work that you do on behalf of patients here in Queensland, particularly to Ms Williams from Belmont Private. Not that long ago a relative had a post-partum psychosis who was treated through Belmont. Again, to echo the work that is done from an acuity and complexity perspective in the private system, it was first-class care, but also to see the level of support that was provided—and I know that that happens both at Ramsay and Toowong Private as well—that is well and truly acknowledged.

In the submissions and also in the testimony today, there were a number of issues raised about funding barriers, private health insurance matters or regulatory issues that may prevent private hospitals in Queensland either providing or establishing mental health services. I am particularly interested in whether there are any issues with the private health licensing unit within Queensland Health that are barriers there? Also with private health insurers, in relation to bundled payments or managed care, which is always floated as a potential funding model, are there any perceived risks or benefits that you see of those models that private health insurers are pursuing?

**Ms Williams:** (Inaudible) I do think there is opportunity (inaudible). I do think there are opportunities particularly for (inaudible) and they are probably people with chronic borderline personality disorders who probably do not benefit from long stays in hospital. I think a (inaudible) package that involves short-stay admission and day program community care would be attractive, and also in the cohort of patients with addictions. They are the two areas in which I think a bundled care model could work. However, I know that a number of our psychiatrists are wary of the bundled care model because of health insurers dictating what they do with their patients, how long they stay and the risks et cetera. So there are opportunities there, but it really needs to be done well.

The other thing with private health insurers is—I am sure my colleagues here have had the experience of them coming to rake back as much money as they can if we are not following their dictated care to be delivered; for instance, each patient having to attend three to four hours of groups a day when sometimes that is just not viable for the patient, depending on their acuity. They are two of the (inaudible).

**Ms Gee:** I do not think there are too many issues with the private licensing unit. A few years ago now, when they did their services capability framework, they engaged very well with the private sector across both medical and surgical, as well as the psychiatric hospital in terms of the levels. In terms of the private licensing unit, I do not think there are too many issues.

In terms of the funding models, I would agree with what Mary said in that there are some benefits to bundling for certain conditions. One of the pitfalls of trying to do that in a private health insurance environment is that each hospital has to contract—unless you are a corporate organisation and you are contracting on a number of hospitals—essentially with nine different funding bodies. By the time you have negotiated with Bupa and then Medibank and then all of the others, the ability to get nine groups of health insurers to agree to the same terms is almost impossible. When I say 'the same terms', it is not even so much the same dollars. It is really challenging to run a service where you have to look at your patients—and it does not happen really in medical-surgical but in a psychiatric hospital—and look at the individual care they need and then the next question is: 'Are you Bupa or are you Medibank? If you are Bupa, I can help you,' or 'If you are Medibank, I can help you,' or whatever. It is really hard when you have nine disparate funding models that allow community services to be provided for this one but not this one, or day programs.

As Mary said, there are some quirks in health insurance in terms of where there are contractual arrangements around the minimum number of therapeutic hours. Where I get very passionate is that it is all commercial-in-confidence, so it is very difficult to have an open and frank conversation, even with your psychiatrists that work with you, in terms of the limitations around certain funding models and what you are able to do, and it is completely blind to the consumer. The consumer will fork out for their private health insurance, but they have no idea the arrangements that Toowong has or Belmont has or New Farm has that can significantly impact their care.

**Dr ROWAN:** Ms Gee, in relation to the Hospital in the Home program that you alluded to before in collaboration with the PHN, is there any private health insurance funding associated with that? Also, with the model of care, who is providing that into the home? Is that nurses or case managers who are visiting? Could you please comment on the model of care and a bit more about how it is funded?

**Ms Gee:** The PHN model is funded through the Commonwealth through the PHN to the community mental health hub and we get paid for the provision of the mental health nurse. In terms of that, it is purely to the public. It can be accessed by someone who has private health insurance, but private health insurance does not pay for it at all.

In terms of the services that are provided into the patient's home, it is generally our mental health nurses who go into the patient's home. We also do run our own hospital in the home service that is funded by some health insurers, as well as the Mobile Recovery Support Service, which is essentially a community support program. That is also provided into the person's home. It is one of the things that we have learnt over the years of running the mental health nurse incentive. Our psychiatrists value a mental health nurse. The PHN is purely mental health nursing. Our hospital in the home and mobile recovery service are multidisciplinary, so it can be a nurse, a psychologist, a social worker or an occupational therapist or a combination of all of those, depending on the patient's needs.

One of the things that our private psychiatrists have said is that it is very easy for a patient to keep themselves together for a 30-minute or 45-minute consultation once a month, and it takes a psychiatrist a while to realise that the wheels are falling off, whereas if they are worried about a patient and they have the support of a mental health nurse who is visiting the person in their own home, they find out very quickly if the wheels are falling off because the washing is not done or they are not looking after themselves or, through avoidance, they try to move their appointments because the house is not clean. It is also very beneficial from the point of view of targeting early relapse and then cutting down on whether the patient has to actually come back to hospital or whether or not they need a change in their medication or some additional supports.

**Ms KING:** Thank you so much, all of you, for coming in here. It is doubtless a relief to all of us to know that you are there providing services to the number of people that you support. I have questions on a couple of slightly different topics. The first is: in general terms, I have heard in this and other inquiries about the reduction in rates of private health insurance in the community. I also recognise that, other than Ramsay, Belmont and Toowong are in higher socio-economic areas compared to vast tracts of Queensland and so concentration of private health coverage is probably not even across the state. We do not have that data. Does the reduction in the number of Queenslanders with private health insurance, which I understand is now down to around 40 per cent, present a risk to your ongoing viability as services?

**Ms Gee:** Personally, I think going back to one of the questions around whether or not we fit into PHNs, as private providers of mental health services we draw patients from all over Queensland. Where we might be situated we may have patients from there, but certainly at Toowong—and I have no reason to think that Belmont or New Farm would be any different—65 per cent of our patients come from outside of our local PHN catchment area.

In terms of private health insurance, of course it is a worry when private health insurance declines. One thing I do think, though, is: if you are a mental health consumer, the last thing you will give up is your private health insurance because it is the one area of health care where there is not a complementary service across public and private. If we do not treat you in a private mental health facility, you are not making admission to a public mental health unit, and that is because of the specialisation of beds and just the way the sectors have developed over the number of years. I think it is more likely that mental health consumers will hold onto their private health insurance.

I said at the outset that one of the very good things recently was the March 2018 reforms which allowed patients that once-in-a-lifetime upgrade. Still to this day, I would say that it happens at least two or three times a week at Toowong where we will have an inquiry for an admission, do a health fund check and find that the person does not have mental health cover. The relief that they and their families find when they know that they can immediately upgrade and get treated is just palpable.

I think we are waiting on some data to see if, when people do that immediate upgrade, it sticks or if they run into trouble and have to drop down again, but I am not sure of the figures on that. I think it is a concern. In terms of mental health, though, it is not something that we have been too troubled with. Anne or Mary may have a different view.

**Ms Mortimer:** I would concur.

**Ms Williams:** I concur, too. Obviously it is an ongoing concern for any private hospital that people would drop their private health insurance, but there has not been in (inaudible) a marked downturn. We, too, have a number of patients from outside the metropolitan area. Particularly with our specialty units, we attract consumers from all over the state. It is not a major concern. I do think with the pandemic, though, and some threats to people's livelihood, a number of people dropped their level of cover. That was our experience (inaudible) data of last year, but there seems to be a surge in confidence again—so whether with immunisations et cetera people are feeling confident and are increasing the level I do not know.

**Ms KING:** I was also interested in your comments, Ms Gee, about lack of transparency for consumers when they take up private health insurance—indeed, lack of transparency within your service where you can or cannot communicate with your clinicians. Is that something you encounter often? You have talked about people needing an upgrade. We have heard about junk policies. Is that a significant issue where people have low literacy about the degree of cover—not just that they have it at present but that they have the maximum level of cover available through their policy?

**Ms Gee:** I think probably the largest concern for mental health is that you really have to have the top level of cover to be covered fully for a mental health hospital, so it is a very expensive level of cover. I think people do get confused because obviously cover for mental health conditions is mandatory, but cover is cover at the default level. I think that is where people get tricked into thinking that their level of cover includes psychiatry so they will be fine. One of the really big concerns I find is where we have particularly young people—so in their early 20s—who are having a first episode of mental health and they have struck out on their own, left mum and dad's policy and started their own. A number of times they have indicated that when they were changing cover the insurers on iSelect, or whoever they have spoken to, were actually getting them into a cheap policy by saying things like, 'Well, you won't need mental health cover, so we can take that out. You won't need cardiac, so we can take that out.' I do not think there should be a cover that does not cover mental health because there is no-one out there or in here who could say that they are not going to have a mental health concern.

**CHAIR:** You mean it's not simples?

**Ms Gee:** It's not simples.

**Mr MOLHOEK:** I was curious around length of stay. Is there an average? Can you comment on the recurrence of patients or clients and the average length of stay for private health?

**Ms Mortimer:** There are generalisations around average length of stay, but some of the different diagnostic categories will be a little bit shorter or a little bit longer. Generally a lot of the stays are around the three-week mark, which gives the patient time for a thorough assessment. Sometimes their first presentation will be a diagnosis, a treatment plan and some interventions, whether that is medication, group therapy, ECT et cetera. From there we will often encourage the patient to go into stepped care, day services or, for those hospitals with home services, to engage with the home service as well. Eating disorders are a little bit longer because of the refeed-in nature of eating disorders; they might be more like a 28-day stay. Even within Ramsay Mental Health, we have some units that might be a little bit lower than three weeks. It is individual-led and presentation-led, but that would be an average.

**Mr MOLHOEK:** Do the insurance companies have caps where you have private cover?

**Ms Gee:** Not so much caps. They will have an arrangement, for example, where you get paid a certain amount of money for the first one, two or three days and then there is a step-down at, say, seven days, the final step-down at 15 and a variety of anything in between there. However, that is something that is blind to everyone but the hospital.

**Ms Mortimer:** We can be caring for a patient who needs to stay with us and they will be well below bed-day costs because of the way the funding is structured, but we continue to offer care and treatment because that is what is required.

**Mr MOLHOEK:** That is not because their policy does not provide for them to stay: that is the contract negotiation between you and the company as to what price they are going to pay you.

**Ms Mortimer:** It will be an individual negotiation—and at what day, yes.

**Mr MOLHOEK:** We should probably hear from Belmont Private Hospital as well, but how many of your services would be residential in-house and how many would be day or outpatient?

**Ms Mortimer:** Every hospital is different. There are often more day services if you have a larger inpatient service because of the volume utilising that stepped care approach. A good, robust service would have a fairly high level of day care—at least half if not a little bit more. We heard Mary say that she has 400 day patients going through her service a week, so it represents a lot of care and treatment.

**Mr MOLHOEK:** Some of that would be peer groups?

**Ms Mortimer:** Day services are predominantly done through group therapy. The patient would come in for, say, 5½ hours and attend three groups of about an hour to an hour and a quarter duration. We also have ambulatory ECT. Patients who leave hospital who had recovery through ECT might also come back for that ECT, so they would come into hospital for that procedure—a mental health hospital. Most of the services offered in day program are through group therapy and then, as Christine described, the sort of outreach services that would be in the home.

**Ms Gee:** If you look at the figures nationally, over the course of a year around 61 per cent of patients receive their care as inpatients, around 20 receive all of their care as day patients and then the other 19 per cent receive both inpatient and day patient.

**Mr MOLHOEK:** Is that in private or across the board?

**Ms Gee:** That is in private.

**Mr MOLHOEK:** So the public health system may well be different to that.

**Ms Gee:** The public health system is a little bit different. That is where it is really hard to compare the two, because we do not really have outpatient services. We have the ability to provide inpatient care, day patient care or community based care, which is a hybrid of the two. Our outpatient services are provided by private psychiatrists to their private patients, whereas the public sector has a much more outpatient, community based thing that is all worked within their particular service. You would have to throw it all together to work out where the differences were.

**Ms Williams:** We have, as Anne mentioned, about 400 day patients. Roughly 300 of them attend full-day programs or half-day programs every week, and the other 100 are made up of the ambulatory ECT and also outreach, our hospital in the home. We see about 80 to 90 patients in our outreach service per week. This model is a really good way to support psychiatrists. The patient might come as an inpatient—average length of stay is about three weeks—then go home and be seen by outreach and day programs. That is one of the difficulties with some private health insurers. They will approve outreach services, hospital and home but not allow the patient to attend day programs at the same time, which is really disappointing because that is the big (inaudible). The model of outreach and day program attendance is a really good way to support the psychiatrist with people who are subacute following their (inaudible).

**Mr MOLHOEK:** I am assuming a proportion of patients would be NDIS funded packages as well?

**Ms Gee:** Not in terms of private health insurance—insured patients—as in getting treatment and being charged through their private health insurance. I would think that most of us are NDIS providers and provide packages outside of the hospital. The other question I think you asked was how many people come back.

**Mr MOLHOEK:** Yes. What is the cycle like?

**Ms Gee:** If you talk to any health insurer they will tell you it is about 99.99 per cent, whereas the national figures show that around 65 per cent of our patients are first-time patients or patients who have not been to a psychiatric hospital in the last three years. The other is made up of people who have been within that three-year period. Obviously some of the mood and affective disorders are cyclical, so you may not see a patient every year, but you may see them every third year.

**CHAIR:** Do any of your organisations have alcohol and other drugs services, either inpatient or outpatient?

**Ms Mortimer:** We are Australia's leading service in private addiction. We have addiction services in all of our states, day and inpatient.

**Ms Gee:** We provide alcohol and drugs services but only to the military. We do a suite of military programs downstairs, so ours are all veterans or current serving members.

**Ms Williams:** We provide some addiction programs for our patients but it is not our primary speciality group. Our sister hospital, Currumbin Clinic, is purely alcohol addiction services. We were leaving the care of patients who require detox and treatment for that down to them.

**Ms Gee:** We are also lucky in Brisbane to have the Damascus unit, which is specialist in alcohol and drugs services, at the Brisbane Private Hospital.

**Mrs McMAHON:** Ms Gee, you mentioned the PTSD programs that you have within the veteran community, but I also think you mentioned that you service WorkCover as well. That would be Queensland government employees and other employees. Can you tell us a little bit more about the pathways between those government bodies to your services and then what that looks like for those people who continue to need those services after they have left the safety net of WorkCover or their employer? Is there a pathway there within the services that you provide, or do you have to onboard them somewhere else to continue their care after they leave the service?

**Ms Gee:** The Department of Veterans' Affairs and military patients are probably around the same as WorkCover patients in terms of where they get their referrals through to the hospital. We do Queensland WorkCover, but there are a number of organisations that we work with that provide their own WorkCover; for example, a lot of mining organisations, Queensland police, and we do a lot of work with the Ambulance Service. Once their acute phase of treatment is completed—our programs are day program based. It is a six-week program, then they go to two days a week for a further month, then they come back at the six-month mark, then they come back at the 12-month mark, and then we follow them up at 24 months. Obviously the team works very closely with each individual and works out what they would require to keep them well. It might refer them to psychology services. A lot of our patients do not come from the Brisbane area, so obviously with the mines they come from a lot of the mining areas. It is clunky when they leave WorkCover. If they get a payout it is probably clunkier than the veterans, who are looked after on an ongoing basis by the Department of Veterans' Affairs. It is something that we have to work with the patient on in terms of then logging them in with a psychologist or psychiatrist who would be available for their ongoing care.

**Dr ROWAN:** I will come to Ms Mortimer just for a Ramsay organisation perspective. You have a number of facilities in Queensland: one in Rockhampton and Cairns. From a regional perspective, I just want to get a sense of when there is a limited workforce, if you are recruiting new psychiatrists into those facilities. Is there also engagement that they might want to provide some public services as well? In other words, there might be someone wanting to establish a private practice but they are also interested or there is a need to provide public psychiatric services or for them to be engaged. What is the level of collaboration between private organisations such as Ramsay and the local hospital and health services to have that joint shared workforce across both the private and public sector?

**Ms Mortimer:** That is very important to us. The expectation is that each hospital would have a good working relationship with the local public hospital. We have done shared recruitment campaigns. Doctors like to have fifty-fifty type of work and there are benefits to working in both, so we have done those campaigns together. We also support the moratorium doctor—that is a very big aspect of our recruitment—and providing Saturday clinics, which is really good for the patient population. They can come in and see doctors on the weekend and those doctors can also provide services at 5 pm. That gives them the opportunity to work in the private sector as well. We see that as an essential part of working locally.

**Mr O'ROURKE:** Ms Mortimer, with regard to the Rockhampton Hospital, where I am based, youth mental health services are always a challenge. I know that Hillcrest does an absolutely wonderful job up there. It is a great hospital. I am just curious: where we have early teens who are covered by private health insurance, for example, does Ramsay provide services to those younger people in our community?

**Ms Mortimer:** In Rockhampton?

**Mr O'ROURKE:** Yes.

**Ms Mortimer:** Not at this stage, but that is a possibility. We have a child and adolescent doctor in Cairns, so we are looking at those potentials. Rockhampton is a smaller unit, with 24 beds, I believe. It is primarily servicing an adult population at the moment.

**Mr O'ROURKE:** Yes, it is. It is a large catchment area. I would love to see some youth stuff happening.

**Ms Mortimer:** Watch this space. As I mentioned earlier, we have a large expansion plan for youth, adolescent and eating disorders together, supplemented with those virtual services to communities that may not have ready access to those specialists.

**Dr ROWAN:** In relation to testimony we have heard with respect to complexity and acuity in both the public and private sectors, that was increasing even before COVID. Obviously there have been issues with COVID as well, but are there specific recommendations that you could give to the committee that could help in that space with respect to those services that are being provided in the private sector?

**Ms Mortimer:** I think I understood the question: how to help with the reform for Queensland and to innovate?

**Dr ROWAN:** That is right.

**Ms Mortimer:** I think in the document I have talked about we feel there are significant opportunities for partnerships, and I believe my colleagues probably feel the same way. Without joining forces we are not going to be able to tackle this problem in Australia. No one sector can do it on their own, and I think combining workforces is key. I do not want to talk about other states here in Queensland, but I think there are lessons to be learned and we are still in the early stages of that. The public sector has recognised that they are going to get training through working in the same service with the private sector, and in kind we are going to get a bit of training around how to better use our peer workforce and some of the areas that the public sector does well. I think if we saw that right across Australia we would get a big improvement in how we reach Australians and Queenslanders with mental health services specifically using the networks that we have here in Queensland as well as the other private providers in Queensland. I think there is real strength in that.

**Ms Gee:** I think it is one of the things we have learned through our work with the PHNs that could be replicated across the state and, indeed, across the country. It is where organisations get to know each other and you get to know the services that are out there. I must admit that, even having been at Toowong, we thought we knew our local community based services. We really did not. Working with one through the PHNs, you actually get to know the services that are available and that are under-utilised and that can help people, which takes the strain off private health insurance if there is a service they can access. I think also it is easy to say that you are going to set up a community based service, but you will always have a patient who arrives who needs more than a community based service. So if you are not in partnership with the local private hospital and the local public hospital, all you have really done by establishing a hub is put another step in and elongate the time that the person is actually going to have to wait to get treatment. If you have everyone there knowing the various referral pathways, it does streamline things and make it a lot easier.

**CHAIR:** There being no further questions, we will conclude today's hearing. I would like to thank all three of you for appearing today and taking time out of your busy schedules. On behalf of the committee, I would also like to extend a thank you to all of your staff, particularly for the work they have done over the last couple of years. I do not think there would have been anywhere easy to work in health care in the last few years. We still have a bit to go yet, I suspect. Please pass on the thanks of the committee to all of your staff. I would like to thank the Hansard reporters: thank you for your help today. Thanks to the committee secretariat. I declare the public hearing closed.

**The committee adjourned at 4.31 pm.**