MENTAL HEALTH SELECT COMMITTEE

Members present:
Mr JP Kelly MP—Chair
Ms JM Bush MP
Ms AJ Camm MP
Ms AB King MP
Dr A MacMahon MP
Mrs MF McMahon MP
Mr LL Millar MP
Mr R Molhoek MP
Mr BL O'Rourke MP

Staff present:
Dr A Beem—Acting Committee Secretary
Ms R Pye—Committee Support Officer

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

TRANSCRIPT OF PROCEEDINGS

THURSDAY, 28 APRIL 2022

Brisbane

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The committee met at 10.34 am.

CHAIR: I declare this public hearing open. I would like to acknowledge the traditional owners of the land on which we meet. Committee members will introduce themselves when they ask questions so I will dispense with introducing the committee. I remind you that this is a proceeding of the Queensland parliament. While you are not required to give evidence under oath, any misleading of the parliamentary committee is a serious matter.

WHETTON, Ms Katherine, Deputy Secretary, Mental Health and Welling Division, Victoria Department of Health (via videoconference)

CHAIR: I welcome Ms Katherine Whetton from the Victoria Department of Health. We have copies of your slides. Did you want to go through those or did you want to make a brief opening statement?

Ms Whetton: Thank you very much for the welcome. I thought I would step through very briefly some aspects of the slides—

CHAIR: Can I ask you to table the document?

Ms Whetton: I was just about to say that I was advised by the secretariat to ask to formally table the presentation. I can see that you have copies.

I would like to start by acknowledging the traditional owners of the lands that we are meeting on today. For me that is the Wurundjeri people of the Kulin nation. I pay my respects to all elders past and present. I would also like to take a moment to recognise all people with a lived and living experience of trauma, neurodiversity, mental health challenges, psychological distress, suicide, substance use or addiction and their families, carers and supporters, those experiencing bereavement and advocates and allies.

I appreciate the opportunity to talk with you today. I will take you through some key aspects of the mental health reform agenda that we are working on in Victoria. I will keep it very brief so we do have time for questions and discussion. The mental health reform agenda in Victoria is vast so I am only going to touch on a few areas at the moment. I have made some assumptions about some things that you might be interested in, but I am very happy to talk about other aspects. I also understand that there might be some things that you would like to discuss that we may not get to today and either myself, in a follow-up session, or my executives would be available to talk further.

I refer now to slide 2. The Royal Commission into Victoria's Mental Health System was an election commitment that was announced by the Andrews government in 2018. The commitment was to set up a two-year inquiry into Victoria's mental health system. The approach to consultation taken by the royal commission was quite unique and vast. Some 1,650 people took part in community consultations. More than 3,000 submissions were received. Overall, more than 12,000 contributions were made by individuals and organisations. The consultation process also had a targeted engagement to investigate the needs of diverse communities, including Aboriginal people, the LGBTIQ+ community and culturally diverse communities. The most powerful contribution to the royal commission's inquiry came from people with lived experience. That included many contributions from consumers but also from their carers and family members.

The royal commission's interim report was released in November 2019. That was followed by the final report, which was tabled in a special joint sitting of the Victorian parliament in March 2021. The final report includes 65 recommendations across five volumes. There were also nine recommendations in the interim report. The final report sets out quite an expansive and ambitious reform agenda over 10 years that works to transform the current system. I have popped on the slide the web address if you are interested in having a look at the reports of the royal commission. There is also a video about the process that was undertaken that you can watch.

On slide 3 I give a very brief overview of what we are seeking to achieve in our work on the mental health reform agenda. The Victorian government has committed to implementing all of the recommendations made by the royal commission. The slide you have in front you gives a summary of the themes of what we are seeking to do. I will talk in particular about our regional governance and

workforce. Overall, you can see from the things on that slide that we are working to create a new system to provide earlier, localised and integrated care, with tailored support for infants, children and young people and culturally safe services for Aboriginal Victorians and our diverse community.

We are working to expand service capacity through the whole system across Victoria—so services across all communities—and the establishment of specialist statewide services. There are mechanisms that we are building into the reform agenda to continually promote innovation and continually improve our practice models and workforce capability. We are seeking to also raise public awareness and understanding of mental health and wellbeing so that people can more openly talk about mental health and mental illness to promote early help seeking in the community and help give people the tools to maintain their own mental health and wellbeing.

On slide 4 is a section that comes out of the royal commission's report. I thought this might be of interest to you. This is the establishment of new governance structures for the delivery of services in Victoria. The royal commission recognised that the current centralised way of delivering and managing mental health and wellbeing services was not meeting the needs of all Victorians, especially those in regional and rural Victoria.

So that our services reflect the needs and strengths of communities across the state, the royal commission recommended establishing eight regional mental health and wellbeing boards. Those boards will oversee a new approach to regional mental health and wellbeing system governance in Victoria. When they are fully established, according to the royal commission's recommendations, the boards will support collaboration with and between services. They will fund and monitor providers. They will support workforce planning, support service access and navigation and also engage with local communities. This is a big change to the way things are delivered in Victoria now.

That slide shows the graduated approach to implementing these boards over a five-year period. It starts with the establishment of interim regional bodies. This is the first step in decentralising governance. While the boards are being established and legislated, the interim regional bodies will assist and advise the department on the implementation of regional governance recommendations and system planning. Those interim regional bodies will start the important process of building relationships with local stakeholders and communities and try to understand local strengths and local needs and perspectives. The chairs of those interim regional bodies have very recently been appointed and we are currently recruiting members to those bodies. Importantly, just going back to point about lived experience, each interim regional body will have among them at least one person with lived experience of mental illness or psychological distress and at least one person with lived experience as a family member or carer.

Slide 5 touches on the workforce strategy. Victoria's mental health and wellbeing workforce, as with any system, is the backbone. It is going to be important to realise the royal commission's vision. Last December the Victorian government released a mental health and wellbeing workforce strategy. It was developed in collaboration with the sector. It tries to set out a coordinated and strategic approach to deliver the diverse, skilled and multidisciplinary workforce that we are going to need for a reformed mental health and wellbeing system.

There are four key priorities that you can see on the slide: building supply; building skills, knowledge and capability; supporting workforce safety and wellbeing and retention; and system enablers to allow for an excellent workforce. As part of that strategy there are a whole lot of programs and initiatives, including programs for allied health and nurse clinicians to be positioned in the mental health workforce. We have also introduced new scholarships and opportunities for training and development.

We are also designing a rural and regional workforce incentive scheme. We will seek to attract and retain more mental health and wellbeing professionals into our regional communities. It is also seeking to build the structures and supports needed for expanding the lived and living experience workforce. That is an emerging workforce in our system. Finally, we are establishing a mental health workforce wellbeing and safety committee—to be co-chaired by the Department of Health and WorkSafe—that will have oversight of key metrics for workforce wellbeing and safety.

Finally, I move onto slide 6. I thought some of you may be interested in the mental health and wellbeing hubs that we have recently established in Victoria. They are available to Victorians of all ages with any mental health or wellbeing concerns. These hubs were not a recommendation of the royal commission, but we opened 23 of these from October last year. This was in recognition of the ongoing impacts of the COVID-19 pandemic. There are some 10 hubs in regional Victoria and 13 in metropolitan Melbourne. These hubs operate in partnership with local community health providers and they are supporting a mix of face-to-face, telehealth, mobile outreach and online delivery to try to get care and support to Victorians wherever they are. The hubs are free to access. They do not

require a referral from a GP. They are available to Victorians of all ages experiencing mental health and wellbeing concerns including lowered mood, anxiety, substance use or addiction, financial difficulties, homelessness or housing stress and social isolation. There is quite a broad range of concerns that people might access them for.

In closing, there is one final point I thought I would make. It goes back to the lived experience point. As we work on this reform agenda in Victoria, and if we are going to achieve the royal commission's vision, we are committed to delivering a new system in partnership with people with lived and living experience of mental illness and psychological distress. That has also meant working across the system. It is a big, ongoing process. It is a culture within our Department of Health to embed lived experience in our decision-making and engagement. As part of this, in December last year we appointed Mary O'Hagan as our first executive director of lived experience in the department. Mary is a former mental health commissioner in New Zealand and she has championed the expertise of lived experience and embedding that in a health service for about 35 years. We are lucky to have her join us. I will leave it there. I am very happy to take any questions you have.

CHAIR: The committee would have liked to have two to three hours with you, Ms Whetton. I have to express our disappointment because we have been trying for several months to get the opportunity. We would welcome the opportunity to have more extensive time with your deputies to go through three key areas in particular we identified we would like to talk more about. I am sure there may be others as well, but they are summarised in your slides. We are very interested in the planning and commissioning of services. We have also to this point identified workforce issues as a major impediment to moving forward in terms of the delivery of services, and the hubs that you refer to seem to be attempting to deal with the missing middle. We are very interested in those three areas, but I do not know that we will get to the level of depth we would like to in the next 12 minutes.

I will start with the planning of services. You have embraced the recommendations from the Productivity Commission and obviously your own royal commission around pushing planning down to a regional level. I presume that you have a fairly similar model of health services in Victoria to what we have in Queensland, where you have HHSs and a centralised health department. What role do the HHSs play in these regional planning processes?

Ms Whetton: Our health services are a really critical part of the system. Health services will work alongside regional boards. The idea is that regional boards will work together. We have a lot of work to do to get to that place. As I said earlier, we are really in a graduated space because it is something that is quite new for Victoria as well. I think some health services have expressed some nervousness about what it might mean to have boards at a local level commissioning and monitoring services. We still have a long way to go to work through how we are actually going to do that, but in the first stages the interim regional boards work closely with health services to understand local needs.

CHAIR: Will those boards comprise representatives from PHNs, community groups and other departments that might have an interest, like housing, police or child safety?

Ms Whetton: We have not designed what the final boards will look like in terms of membership. In relation to the interim regional bodies we have gone through competitive recruitment processes for seeking chairs and members of those committees. Having seen some of the early parts of the process and who has expressed interest, we have people who are CEOs of Indigenous cooperatives, we have people who are on primary health networks and we have people who are interested in community health, so there is a real mix. We have tried very hard to appoint chairs so far who do reflect those local communities. We expect that we will try and bring in all of that different mix of people to the final boards as well.

CHAIR: Presumably, when a board is finally established in terms of developing a plan there would be pretty broad consultation and seeking of input into that planning process?

Ms Whetton: That will be a very big part of their work. Again, there are interim regional bodies, and one of their key tasks in the first instance is to build relationships with local communities and local stakeholders, and the approach to any planning would be a very deep engaging process. It would be a shame to set up something at a local level and not get that really deep local engagement.

CHAIR: Presumably, HHSs have a similar role to those here. From a state perspective, we fund everything from the ambulance through to rehabilitation services and all the acute stuff in between for both health and AOD. How are you going to manage the funding part of this? Will these boards have some control over the funding of services, or are you just going to ask your HHSs to make what they have stretch further?

Ms Whetton: A decision is yet to be made exactly how that will happen. As I say, because it is such a graduated process there are still things like that that we need to work through. At the moment, all of our health services that run mental health services have received an uplift in funding. That is being managed by the department at this stage. Ultimately, we would need to design how the board would then move on that. I think, similar perhaps in Queensland, it is quite a different approach for us and it is not something that is undertaken in the broader health system just yet either.

CHAIR: Presumably, much like Queensland your state government has no control over the primary healthcare network and GPs and how they deliver and implement services and are funded. Did the royal commission make any recommendations in relation to that, and how are you managing that part of the service?

Ms Whetton: The royal commission did talk a bit about the need for better partnerships between levels of government, saying that ultimately we are really not serving Victorians well by having such distinct roles and not coming together in partnership. Similar to Queensland, in Victoria we have been working with the Commonwealth government on the national agreement for mental health and suicide prevention and we have also recently signed a bilateral agreement. Going through that bilateral agreement, there is an attempt in great detail to get much better workings across levels of government so there is much more integrated care for people.

CHAIR: Are there any other questions around planning from committee members? We might move on to workforce. You talked about your strategy's core components. Can you step us through the wellbeing part of this? Are you anticipating a completely new workforce that is focused on wellbeing, or is this more about the wellbeing of the workforce?

Ms Whetton: There is both. The wellbeing and safety of our workforce is incredibly important, as it is for all workforces, and it is something that the royal commission called out. Because mental health services have been so underfunded for such a long time, we have the workforce saying they face distress every single day because they cannot provide the care, treatment and support that they are trained for and would like to do. There is a focus in the royal commission about trying to protect and enhance workforce wellbeing and safety. All states and territories have had these challenges with the pandemic. It has really had some big impacts on our workforce generally across the health system. There is a focus on really trying to enhance the wellbeing of the workforce, partly because we cannot afford to lose people from the workforce. Every day we hear that people are leaving the workforce because they can no longer be supported.

In terms of wellbeing services, the royal commission really does try to address even the language. It is not just the mental health system now; we are really talking about a mental health and wellbeing system. We are trying to move away from it purely being about mental illness. There is a much bigger focus on early help seeking. One of the things the royal commission recommended is that health services must form a partnership with a community service provider, a non-government provider, to start bringing forward wellbeing support into some of those tertiary services. It goes a bit to your comment too about trying to address some of that missing middle.

CHAIR: You mentioned your rural incentive scheme. I suspect that, like many things, it is probably early days, but do you have any broad parameters that are being looked at in terms of incentivising work in rural areas?

Ms Whetton: I can take that on notice and get you some more information because we are in the middle of design now. I think it will be some of the things you see in these types of schemes. I was involved in one a couple of years ago in the education department, where it is really challenging to attract a workforce and then retain them, so it is incentives that relate to settling into communities, housing, training and support they might receive. I am very happy to provide some additional information if that would be helpful.

CHAIR: It would be, thank you. In relation to your lived experience workforce, is it anticipated that your government is going to seek a standardised scope of practice, a training and development approach, to a lived experience workforce?

Ms Whetton: I am not sure if I would say exactly it is a standardised practice, but we are really trying to build that part of the workforce. If we look across the overall mental health and wellbeing workforce, it is the most emergent part of the workforce where we still need to do a lot of work about the levels and standards that you would want in that type of workforce. Again, it is early days and I am happy to provide some more information. It might go to your point earlier that, if we had more time, I might be able to get someone from my team who has that particular expertise.

CHAIR: It is an area that we would be interested in. We have heard many definitions of the lived experience workforce and there does not seem to be any standardisation. Different organisations have very different views of what that looks like. Are there any other questions from other committee members around workforce?

Mr MOLHOEK: In terms of the workforce strategy, where does telehealth fit into that, and do you have any views around the value or otherwise of telehealth?

Ms Whetton: I am not sure that telehealth features strongly in the workforce strategy, but certainly it is something we are looking at. I mentioned earlier that the current mental health and wellbeing hubs have included telehealth as part of that because we are trying to get a really good spread across the state. We have 10 in regional and rural Victoria, and mobile outreach and telehealth is a part of that. We are also establishing local services. We are calling them our local adult and older adult services in the state. They are also seeking to address that missing middle and getting people to seek help earlier. I imagine part of that will include some telehealth. One other thing I will mention is that the royal commission also said there should be trials undertaken of more digital approaches to the delivery of services. We are not yet there to set up those trials, but the idea is, I think, that you may use more digital platforms for people to seek help.

CHAIR: Can I just come back to scope of practice in relation to other practitioners. Has the royal commission and subsequent implementation looked at broadening or utilising all health professionals across all of their scope of practice?

Ms Whetton: We have in the workforce strategy suggested that a piece of work to be undertaken is looking at scope of practice in the workforce. It is yet to be commenced, but it is something that we have said is a piece of work that is needed.

CHAIR: We have no time left, but we did want to ask you a little bit about mental health and wellbeing hubs. You did mention in your opening statement the importance of carers and families in relation to the work you are doing down there. One of the submitters talked about the Victorian model of carer consultants. I know from my experience that family involvement in both mental health and non-mental health care is often quite challenging. Can you step us through how you are approaching that in Victoria?

Ms Whetton: We recognise that it has not been done well before. It can be tricky, but it is something that we are seeking to do a lot more of. We are working with our peak bodies. There is a peak body for carers in Victoria, so we are working really closely with them on what it looks like to really build in that involvement of carers in all mental health lobbying services. The carer community and lived experience community would say that the royal commission has really been the turning point for the involvement of carers and families. It gives us a really big impetus to increase it. Again, I could come back with more detail on specifically how we are doing that.

CHAIR: I would like to thank you for your submissions and your presentation today. You have taken a question on notice. Could we have a response by 12 May? We would welcome the opportunity to talk to some of your deputies in more detail around this, so I might ask the secretariat to work with your team in relation to finding a time that works for us. I am sure we will have some questions on notice to pop through to you after the session. Thank you very much for your time this morning. We greatly appreciate it.

Proceedings suspended from 11.02 am to 11.17 am.

CHAIR: I will just run through what I should have run through before but did not due to time constraints. I respectfully acknowledge the traditional owners of the land on which we meet today and pay our respects to elders past and present. We are very fortunate to live in a country with two of the oldest continuing cultures in Aboriginal and Torres Strait Islander people, whose lands, winds and waters we all share.

I will introduce the committee members. I am Joe Kelly, member for Greenslopes and chair of the committee. Mr Rob Molhoek is the member for Southport and deputy chair. Ms Ali King, the member for Pumicestone, will be joining us later. Ms Jonty Bush, the member for Cooper, is substituting today. Mrs Melissa McMahon is the member for Macalister. Mr Barry O'Rourke is the member for Rockhampton. Ms Amanda Camm is the member for Whitsunday. Dr Amy MacMahon is the member for South Brisbane. Mr Lachlan Millar, the member for Gregory, is substituting for Dr Christian Rowan, the member for Moggill.

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

These proceedings are being recorded and broadcast live on the parliament's website. Media may be present and are subject to the committee's media rules and chair's directions at all times. You might be filmed or photographed during the proceedings and images might also appear on the parliament's website or our social media pages. Please turn your mobile phones off or switch them to silent.

I remind everyone watching the broadcast or reading the transcript that if today's proceedings raise any issues for you, please seek support. Contact details for support organisations are available on the committee's webpage.

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

KINSELLA, Mr Kieran, Executive Director, Addictions and Mental Health, Metro South Health, Queensland Health

TURNER, Dr Kathryn, Executive Director, Metro North Mental Health, Queensland Health

CHAIR: We are inviting back Queensland Health today so that the committee can follow through on a number of issues that we have identified during the inquiry. Do you want to make a brief opening submission or are you happy for us to go straight to questions?

Prof. Allan: I do have a brief submission.

CHAIR: If there are key points you want to raise, I think that would help to set the tone.

Prof. Allan: I also respectfully acknowledge the traditional owners of the land and pay my respects to elders past, present and emerging. I also would like to acknowledge people with lived experience of mental health, drug and alcohol issues and suicide issues and particularly their families, carers and those people who look after them. That is why we are here.

I am Associate Professor John Allan. I am executive director of the Mental Health Alcohol and Other Drugs Branch and, as you have said, I have appeared a number of times. I welcome the opportunity to come back. I have followed the activities of the committee with great interest. Queensland Health has already, of course, provided a number of briefings and appearances. I want to go into a bit of a summary of that. Today I really want to just reiterate the key issues facing Queensland Health mental health, alcohol and other drug services; that is, the significant increase in the demand for our services and the critical need for resources to address this demand.

In the last five years, from 2016 to 2021, the Queensland government committed over $350 million to funding state funded mental health, alcohol and other drug services. Unfortunately, the demand for Queensland's publicly funded services has grown significantly faster than the Queensland population and available workforce. The system is under a great deal of pressure to meet demand that it is not appropriately funded for. COVID-19 has also had an effect. We are doing

something about that. I have previously described how we have used the latest versions of the national mental health service planning framework and the Queensland drug and alcohol service planning model, QDASPM. Both are very sophisticated, evidence based tools to get us to the optimum range of services across the full mix of the population. We use these services—taking also into account the current utilisation data from our services, a review of the existing infrastructure and bed stock, the outcomes of the gap and needs analysis, consultation with key stakeholders and relevant state and national policy directions—to estimate the need for mental health, alcohol and other drug services and the level and mix of services required for the given population. I note from the Victorian evidence just given that it is probably worth noting that Queensland has a long history of actually planning and having mental health, drug and alcohol plans, unlike Victoria, which we are very proud to bring. Our modelling shows probably what people have been telling you in this inquiry as well; that is, there is a need for significant additional resources and there is significant demand.

Just to reiterate what I have earlier said, although the planning framework represents an ideal situation of a best practice service system, it shows that Queensland is at 61 per cent of the projections for acute bed capacity, at just 45 per cent of the projections for community bed based services and at a little more than 60 per cent for community based services. Obviously we have identified gaps across the entire system—children and young people, perinatal and infant mental health, eating disorders, older persons, prisons, alcohol and other drug treatment, forensics and mental health. We have previously stated that Queensland is low in terms of comparison to other states. I will not go into that. One good fact I will bring up about our low comparisons is that Queensland leads the way, per head of population, in the number of consumer and carer consultants and leads this way in terms of the number of Aboriginal and Torres Strait Islander mental health workers. However, I also add that we are still not what we need to be in terms of what would be required. I just note that we are in one place ahead of other states in doing that.

I want to make a couple of other points. We have had a number of plans. Our last plan, Connecting Care to Recovery, has been evaluated. It has been a signpost. I will table today a copy of that evaluation, if I can. I will make electronic copies available to the committee. It is really important to note that it also talked about the need for further investment. We have identified, I guess as everybody talks about, the need to invest in: workforce development and expansion—that is probably our critical feature; clinical improvement and practice change; digital information and technology infrastructure; built infrastructure, including hospital and community bed base and ambulatory models of care; policy planning; and funding and commissioning of services. We have done a lot of work around that and where we need to take that. There is also data monitoring, evaluation and research and then of course governance and quality. I add that Queensland has a very good governance system in its hospital and health services. The integrated mental health, drug and alcohol services are an integral part of those services—unlike Victoria, which had around 60 disparate mental health services that were rather unconnected and needed to take that stand and bring them together in eight services. We have a reasonable governance structure. We are very happy to talk more about that as we go along.

We note that there is some good news as well. We have a robust system and are working on a new plan. As I mentioned previously, a robust system would enable us to do that. We are working on that plan—I do not have that ready; it is still going through a government process—but I do have our new digital information strategy and roadmap, which is part of that plan. I will also table that for you. That talks a lot about how we can use digital innovations—not just how we can build on the telepsychiatry that we already have but also how we can use things through the web and give people access to their own data and their own information. We have been going through a process of making that data and the information that we have more available to our partners. For example, we share that with our NGO partners, with GPs and so on. We think there is a lot of future in the digital strategy as well. I note that.

On 22 March, Queensland and the Commonwealth finalised the bilateral schedule on mental health and suicide prevention as part of the National Mental Health and Suicide Prevention Agreement. That allows for improvements in suicide prevention and mental health for Queenslanders. Particularly of note, we are entering into a system with the Commonwealth to build a number of those community based hubs for adults and for youth and are working on enhancing headspace in that space. It sets out the responsibilities of the Commonwealth and Queensland and their respective financial contributions. I also want to make sure I table a copy of that for the committee as well. These are strategic to our successes.

I will just talk about one other topic and then introduce my colleagues. While developing the plans, we have worked very closely with our hospital and health systems. I am sure you are aware that the hospital and health systems are struggling to address the demand in both emergency

departments and mental health, alcohol and other drug services. COVID-19 placed an increased pressure on that already overloaded system. These are some of the difficulties facing them. Our dedicated community mental health, alcohol and drug workforce is facing exhaustion. While staff are working their best for consumers and their families, we are at risk of losing them due to increased demand and lack of available services, somewhat like Victoria. Alongside funding pressures, it has become increasingly difficult to access and retain skilled and capable staff. This is having a particular impact on regional and remote services. Decisions to admit and discharge are at risk of being based on available resources, for example beds, rather than what is clinically needed for the person. The demand for high-security beds for people who require them is growing. Difficulties in providing that appropriate care to consumers puts them at risk, as well as staff and other consumers. I note that Dr Ed Heffernan, the director of the Forensic Mental Health Service, is addressing you today. I expect that you will hear more from him about that.

The metropolitan hospital and health services are increasingly required to support regional service delivery to meet need. The centralised availability of specialist services means that consumers are often having to travel as well to access them. HHSs are responding to people with lived experience of intellectual and developmental disability who may not be experiencing a mental illness but there is no other place for them to go, particularly when the NDIS is not meeting all of their needs. Hospital and health services play a critical role in clinical care providing for people experiencing mental health crisis, including suicide. We have done a lot of work in suicide prevention, but of course that is not often well funded and is often done over and above what people are already doing. I note that the committee will be hearing from my colleagues in the Torres and cape, and I look forward to watching that as well.

To talk a bit more about some of the pressures facing the hospital and health services, today I have invited two of my colleagues: the executive director of Metro North Mental Health, Dr Kathryn Turner, who is well experienced in crisis system reform and suicide prevention initiatives, amongst many other things in psychiatry; and the executive director of Addictions and Mental Health, Metro South, Mr Kieran Kinsella, who has experience in his long career as a nursing director and has experience in rural mental health settings. They have also worked in other Queensland Health settings. I note that they have been endorsed by their colleagues from the mental health and alcohol and drugs leadership group to represent the HHSs here today. I would like to thank the committee and assure you that Queensland Health is deeply committed to improving the mental health and drug and alcohol issues of our consumers in whatever way we can help. Thank you.

CHAIR: I note your plan and the evaluation of your plan. It seems to me that a lot of these plans that we refer to are high-level and statewide and that the Productivity Commission has recommended that we look at more regional based plans. That seems to be the approach that Victoria has taken. We have heard of some HHSs that engage in regional planning processes, but it seems to be not consistent and there does not seem to be consistency of who is actually involved in that plan. Often the evidence we have heard on the ground is that the perception of the HHS is quite different to other stakeholders in those particular communities. Does Queensland Health have a view of how the state might roll out a planning process that is anticipated by the Productivity Commission findings?

Prof. Allan: We do. I just note that, when we have those high-level plans, they are actually made up of multiple small plans. This planning process we are going through is HHS by HHS. We have actually consulted with the HHSs. We have talked to the PHNs. We have talked to the providers in that area. We have talked to the consumers and carers in that area. They have talked about their needs along with what our planning framework says and they have put up their top priorities for that. We have taken that regional planning approach already through that HHS situation.

The national plans, the Productivity Commission and the previous fifth plan called upon us to work with the PHNs to develop those local regional plans. Queensland has led the way in the development of those regional plans with the PHNs and with other stakeholders. We would work to do one and look at what that regional body would look like in terms of that planning process. We think it is more than just the PHNs. Although they represent the Commonwealth, there is also local government and there are other parts of government agencies as well so we would look to see how that works. I will ask my colleagues, who actually engage in doing that regional and local planning, to give you some good examples, which I know they can do.

We think we are well placed to do that because we have used the planning frameworks properly. I do not want to be unkind to Victoria, but they did not embrace those planning frameworks. They have had separate development in different ways. They have not had a standardised system. They have not embraced the PHNs up until now, whereas we have done that over a number of years

so hopefully we are in a better place to do that. I think we will have a mixture of centralised funding and dealing with that, but we do need to have that localised planning at that level and that is what our HHSs can provide. I might let my colleagues answer some of those local questions.

Mr Kinsella: I am happy to describe briefly what we did in Metro South around regional planning. We are really lucky: our borders are the same as Brisbane South PHN. Two years ago we embarked on our foundation plan and started setting that up. Our foundation plan was signed off by the HHS board and the PHN board two years ago this June. Within that foundation plan we have set up place based consultation groups. For Metro South, we have a place based group at the PA, South Brisbane, Logan, Redlands and Beaudesert. In those groups, PHNs represented the NGO state commission and the other NGOs within the region. We have extended it now to also include the councils, and we include primary care where we can get them involved as well. Over the past 18 months, they have been informed of priorities for our regional plan which we are currently in the process of developing.

We had some emerging priorities come out at the very beginning—things like suicide prevention and child and adolescent—and, rather than waiting the two years to start doing some work on what were very clear priorities, we set up chapters, as we call them. Those chapters have already started that work around those areas. We have a suicide prevention structure within Metro South. Within the HHS we have a committee and group, but we are reporting to a regional committee and group as well so we have a nice structure where we bring all the agencies together. It is very similar for child and youth, which is a really challenging and increasingly demanding area for us in the region. We will be signing off our foundation plan as completed by June and then we will be moving into the regional planning and putting the final points on that. Although we are working on it, we will have the document ready by September.

CHAIR: You identified the increase in demand as the No. 1 challenge going forward. The question I have is in relation to what we believe is causing that increase in demand and what steps are being taken to resolve that. Is it simply population growth? Has COVID had a role? Is it this missing middle, the fact that we are diagnosing people and then offering no treatment until they are in crisis, which is where Queensland Health seems to step into the fray? What is causing this increase in demand? What are our steps to try to address that?

Prof. Allan: I think all the things you said are actually part of the answer to that question. There are three main things. One is that obviously there has been a population increase, so just in terms of serving that population increase there are pressures. A lot of the population has been where there are not good services otherwise—so where the primary care and so on has not been good for them—so Queensland Health steps in to do that. We have always done that in the rural and remote areas, but we are often having to step in now in the regional and outer suburban areas as well. That is No. 1.

No. 2 is, as I am sure you have heard in this inquiry many times, the early stages of life are when serious mental illnesses arise and there does seem to be worldwide this increase in mental health problems for young people because of other pressures. We have this huge increase in demand from young people. There has been a 19 per cent increase for youth in terms of suicidal presentations. Some of that is COVID, some of that is the world and some of that is the way things are at the moment. Nobody knows the exact answer to that. I have heard a number of experts give that evidence here for that. That is another problem.

The other one is that there is a change in patterns. There are people unable to get into GPs. There are issues, as we have heard, about people presenting to emergency departments because there is just not that pattern of care for them and we need to go back. Picking up on the missing middle and the missing middle not getting treated and then becoming a bit further from the middle towards the far end is all part of that. There is also greater awareness, and people are actually recognising and wanting to do something about themselves.

CHAIR: The committee has heard evidence that the NDIS has driven more of an individual, one-to-one service approach and we have lost a lot of the capacity around those group organisations that provide psychosocial support which can contribute quite significantly to reducing the development of more serious mental health issues. Does Queensland Health have a view on the need to look into that community sector and ensure there is a full range of services for people, particularly in those early phases of the disease process?

Prof. Allan: Yes, we do. I think there is a Commonwealth responsibility and a Queensland Health responsibility. As I am sure you are aware, we cashed out money to the NDIS and people have talked about that. My colleagues can talk more about this. What we are noting is that people who have quite significant intellectual disability and mental health problems who might have

significant packages are not able to fill those packages because of lack of service. Or if they do fill the package, because of challenging behaviours and because of a lack of support to the service providers—because it is a different system to what it used to be—they might find their services terminated so they end up in hospital and occupy beds.

Queensland Health is very interested in making sure there are safe places for people to go rather than being in hospital. We are interested in making sure there is that range of community supports that people can have. Do we have organisations with the skill and capacity to take on those difficult cases to develop that skill? Some of that is a Commonwealth responsibility; some of that is for us. For example, we meet about that regularly in looking at those people with challenging behaviours—what to do and how to help them. My colleagues can probably talk about some of those examples ad nauseam, I would imagine.

Dr Turner: I will not reiterate everything you have said. The interface with the NDIS is a very significant issue, and most of us would consider that there needs to be considerable work done on that. We frequently get a significant number of our beds taken up by people who have not been able to access the supports and the appropriate accommodation they need. I think it is a very significant issue that we have lost some of that capacity within organisations in the community that we used to have in terms of developing their skills to be able to take on this work. That is very challenging with the current way that it works.

CHAIR: A range of areas have been identified as significant deficits, and then there is a range of areas where there is some good initial work happening but it probably needs to be more systematic. We have only four mother and infant perinatal mental health beds in the state, and we still have the one dedicated detoxification service at the Royal Brisbane hospital which was there when I trained in the 1980s, and we have no more than that now. We have some good work being done in alternative entries to EDs around crisis care and those sorts of things. We have heard good evidence and submissions from the early psychosis intervention services and the Eating Disorders Association of Queensland. There seem to be things we are doing well that we could be doing a lot more of, as well as things we probably should be doing that we are not doing enough of. Are these things anticipated in the planning processes? Are we on track to improve these things?

Prof. Allan: From what I can say without saying everything, of course all of those things that you have mentioned—about mothers and babies, drug and alcohol, eating disorders and so on—are anticipated. I think we have good models; we need to scale them up and we need to look at statewide coverage. Queensland does suffer a bit from our geography. We have to think about how to get the right kind of service for the people of the north or the people of the west as well as those city based services. We have good models and they need to be scaled up. Hopefully, the planning process has anticipated all of those gaps, but whether we can get to the scale of everything in the first phase of that is a challenge. As I mentioned, just recruiting the workforce is a challenge. We have tried to cover all of those gaps, I would hope.

Mr MOLHOEK: Professor, I am curious in respect of the workforce and the demands—and you have indicated that there is a lot of pressure on the system and a massive increase in demand. In one of the earlier hearings we heard evidence that suggested there are aspects of the mental health system that are quite inefficient—in that the concern around risk is so escalated that a lot of mental health professionals within the public health system particularly are having to spend up to 80 per cent of their day doing paperwork, answering questions and ticking boxes. That is then exacerbated by the fact that the nature of a lot of mental health clients is that you get no-shows for appointments and the like. Has there been any thought around what could be done to turn that upside down and actually create a better system? That would require increasing risk but perhaps it could produce much greater outcomes.

Prof. Allan: There is. I will hand over to my colleague Kathryn Turner, who is the statewide lead in this. Do you want to speak first and I will come back to it?

Dr Turner: First of all, I would like to say that some of that is probably not the reality. They do not spend 80 per cent of their time doing that. Our clinicians are very hardworking. They are seeing lots of patients every day. There are certainly some frustrations with the system, but some of that is because of the demand so any extra work feels like a huge imposition in terms of documentation.

What we know is that some of that documentation and systems is incredibly important in terms of improving safety. Consumers in our services deserve comprehensive care so we do need to do this work. A lot of the work we have done around suicide prevention is absolutely not to heighten people's concern about risk; it is to support our clinicians in working collaboratively with consumers and their families to manage a lot of the risk and improve their care.

The work we have done at the Gold Coast around suicide prevention did not add any extra forms. What it did was it trained our staff—and that is what we need to do as well; we need to invest in staff. If you talk about also working top of scope, it was about training up our clinicians to be able to provide actual psychological interventions for consumers. We were able to demonstrate that we had a 35 per cent reduction in repeat suicide attempts by placing people on a pathway and training our staff to do that.

We have had an increased number of suicidal presentations, but the thing is that we know things that actually work. What we know about the evidence base is that we had to change practice in our mental health services. We had to shift away from the idea that we could predict suicide and we could find the small population of people who were high risk and then look after them. We had to shift towards actually understanding that we have to provide interventions for a much broader range of people who come into our emergency departments, for example with self-harm. That put an enormous extra stress on the system, and our clinicians stood up to the test and were able to respond to that.

However, we also have evidence that we have hit a wall of fidelity. Having fidelity in all the parts of the pathway is highly likely to be the reason that we had a 35 per cent reduction in suicide reattempts. We have evidence that, with the increasing number of presentations, the higher the number of presentations the lower fidelity on the pathway, and that was a reasonably well resourced acute care team. We have excellent interventions that can actually make a difference, but we do not have a hope of being able to actually implement that because we are not funded for that.

The thing about the National Mental Health Service Planning Framework is that it does not actually address suicide in a crisis. Not only does it not address suicide in a crisis; it does not address this changing paradigm which understands that we do need it, even briefly, but a very large volume of patients takes a lot of extra time.

Mr MOLHOEK: I think we are straying a little bit from the question. Dr Turner, it is always interesting when we do site visits, and it is often the conversations you have with people when the microphones are not on. In a number of locations, some of the staff at the coalface were saying things to me and others on the committee like, ‘We just want to get on and help people, but the amount of paperwork we are saddled with is just killing our motivation, it is killing our aspiration to help people and we are just constantly being dragged back.’ I cannot remember the content, but one of the staff showed me the sheath of paper that had been produced to process one patient. There were questions like, ‘Can you name your mother-in-law’s mother-in-law from the 1700s?’ I am exaggerating but it seems that the system has become so paranoid around risk that we are wasting good time of professional people to do the therapy work because they are busy filling in paperwork. We heard earlier submissions also from the private sector suggesting that mental health practitioners in the private sector see probably eight to 10 patients per day and spend 10 to 20 per cent of their time on paperwork and the opposite is true of the public health system. I accept that that is a gross exaggeration, and I am not in any way wanting to be disparaging, but I think for senior personnel within the system our job as a committee and your job is to make the job of our frontline workers easy and not more complex.

Dr Turner: I think I did address that in terms of focusing not on the paperwork but on upskilling clinicians. I am very familiar with the paperwork and have filled in plenty of the clinical forms that we need to do. There is absolutely a frustration. There are parts of that which absolutely frustrate me. Some of it is about the whole interface with the electronic medical record. We did put a submission into the Queensland health inquiry, called Making Time to Care, which addresses this exact issue.

Again, getting back to my point about consumers deserving comprehensive care, they deserve good quality care but it is a complex issue. I think the digital strategy that was mentioned before is, I would hope, part of the solution to addressing this. We need to look at how we interface with the electronic medical record. This is not exclusive to the mental health service in Queensland. We know that electronic medical records—I have had plenty of frustration with other electronic medical records in the broader health system—do absolutely increase safety and improve our communication et cetera, but they do lead to an increased sense of burden of documentation.

Mr MOLHOEK: My concern, though, is that there is a small group of people who are getting care that are safer but at the expense of hundreds, if not thousands, of others who are not getting the care they need because the system just does not have the capacity to cope.

Prof. Allan: I will take that. There are actually thousands of people getting care. There are 20,000 people getting care at any one time.

Mr MOLHOEK: Sorry.

Prof. Allan: The other thing about the electronic system is that it is digital information, but a lot about what you are saying about reducing that burden, getting the right information at the right time about the right person having analysis—unlike private practice, our information system is available to every clinician in Queensland. If a person presents at the PA but they show up in Nambour next week, everything from then is available. Private practitioners' notes are not available, so you cannot have the short cuts and things that they might use. We do have to actually have material for people. That is important to say.

The other thing is that—I think you are right—we need to get people working at the top of scope, but, as Dr Turner points out, the problem is that if you are really under pressure it is very hard to be perfect all the time or to be at that level. You are right, in a way, that we are governed by risk. It is very difficult when you are in the middle of the night talking to someone about what has happened to their son or daughter, or to a clinician who is talking about that, and you are asking, 'Well, what notes have you got? What is the coroner going to ask you?' That is a reality that we are actually responsible for people's lives. I expect a serious note on record keeping and understanding of patients and families. That is important, too.

CHAIR: It is an old conundrum: if you want to find a constipated patient, look for a blank bowel chart, I always say. I will go to the member for Macalister for the next question.

Mrs McMAHON: Thanks for that, Chair!

Mr MOLHOEK: That is going to be the quote of the week.

Mrs McMAHON: In reviewing a number of the submissions before the committee, there have been a couple of continuing threads. I know we have not specifically addressed it throughout the committee, so I thought I might take this opportunity. Some of the submitters make reference to ECT as well as the current Queensland Health locked wards policy. Can anyone here provide a bit of background to the committee on the role of those therapies and also on the current locked wards policy and where Queensland Health stands on those?

Prof. Allan: ECT, electroconvulsive therapy, is a vital and effective mental health treatment for people with serious mental illness, particularly for depression and, in some cases, for bipolar disorder and for schizophrenia as well. It is a highly regulated treatment: we have an ECT committee that overlooks that, we have a set of standards and we have documentation around that. It is well regulated when done under the Mental Health Act. Again, it is very regulated by that and by the Mental Health Review Tribunal, so there is quite a lot of review around that.

In my view, it is a safe and effective treatment. I know that people have some views about it and want to say that it is horrific, barbaric and so on, and they think about the *One Flew Over the Cuckoo's Nest* image which is now 60 years ago. I have been around for 40 years in psychiatry. There has certainly been an evolution in terms of the science, the technology and the safety and capacity of ECT treatment. I would stand and defend ECT as an important part of the armamentarium. Again, it is about consent, understanding—everybody understanding what the benefits and risks are—and monitoring properly, which we actually do. There are standing ECT committees credentialing for people who do it.

Mrs McMAHON: Is it a voluntary or involuntary practice?

Prof. Allan: It is a voluntary practice in the first instance, but it can be administered to people under the Mental Health Act. That is in a situation where their life and safety are in danger. A person might have severe depression, for example. They might stop eating and drinking and say, 'Well, I am worthless.' They might have a delusion: 'I have worms inside me.' They might refuse to do that, so it is a medical emergency to actually treat them. You are not going to be able to wait around for two weeks for medications to work.

Mrs McMAHON: Can you speak to the locked wards policy within Queensland Health?

Prof. Allan: The locked wards policy is a policy that has been around for a while. I am sure people have spoken about that. It came into being seven to eight years ago—I cannot remember the exact time—I think at the end of 2013, something like that. It is a bit longer than seven years. It was brought in at the time because there was concern about people who were at risk absconding from hospital and subsequently suiciding.

The thing that is really good about it is that the HHS has done a lot of work around that absconding, so the rates of absconding have come down. We have now begun some trials of unlocking the wards. There is a trial that has been occurring at the Gold Coast around having an unlocked ward and that has just been extended. If that is successful, we are hoping to move to more trials of using open wards.

I think it is a point of debate about safety and about issues of rights. Nobody who is not under a mental health order is locked up against their will—they are able to leave and come and go—but it is an extension of the issues around safety. As we have had more and more presentations and people are becoming more and more acute, there are particular issues of safety for people in hospital. Having a loved one leave hospital when they should be there being looked after is not always a pleasant experience either. It is, again, one of those compromise issues. We are hoping that with better buildings, better staffing, the education of our staff and the work that has already been done we will be able to move to a situation where some wards are locked and some wards are unlocked.

Mrs McMAHON: One of the other frequent responses we receive in some of the submissions is the role of accredited or qualified counsellors within the mental health workforce and also psychotherapy. It is not something we have heard too much about in verbal evidence towards the committee. Can you provide some information around the status of those qualifications or occupations?

Prof. Allan: There is a difference between counselling and psychotherapy. They are not—

Mrs McMAHON: Yes, I understand they are two different things.

Prof. Allan: Psychotherapy is a particular arm of armamentarium, as is counselling, in terms of treatment of people with mental health problems. Psychotherapy is actually a very important part of the recovery process for people with quite serious conditions. When we talk about people working at the top of scope, we would like to see more patients receiving psychotherapy and we would like to see more of our staff practising psychotherapy.

For psychotherapy there are particular training programs. There are various forms of psychotherapy. I am sure you have had people talk about cognitive behavioural therapy and its basis. Then there is psychodynamic psychotherapy. I have had training in both of those. They both have their place in what we need to do, but we particularly need to have therapies that are based on cognitive behavioural therapy and DBT, dialectical behaviour therapy, for those with personality disorders. We engage in training people to do that and we have people who are able to do that. The issue, though, as I think Dr Turner mentioned, is workload, that sometimes people do not have an opportunity to practise those skills or do that with their patients.

One of the reforms we want to make is to actually have people able to do that therapy, to spend particular time delivering that type of therapy. Already in the last plan we did some work around therapist-only clinics. I can talk of the success of the one in Metro South, where the psychologists and others were actually able to go and do that psychotherapy to great benefit for the patients but also for their own professional development and career. However, to do that, you need to have time and you need to be organised, and that is what we plan we will do in this as we progress.

Ms CAMM: Professor Allan, you touched on comparison to the Victorian model about regional planning, regional boards et cetera and how well our state has progressed and is working. On our travels, and in my community—and I will encompass that as the entire North Queensland PHN, which I am a part of—we have heard of the pressures and the issues around workforce attraction and retention. We recognise that it is not all that attractive perhaps to live in Mount Isa or Townsville or what have you, and different HHSs are doing different things to try to attract workforce. However, when we have Wide Bay and other HHSs in North Queensland all competing for recruitment of mental health specialists, whether they be psychiatrists or those working with adolescents, and we have very few or no beds with regard to adolescent mental health and wellbeing north of the Sunshine Coast, how effective do you see the localised workforce planning and the role that Queensland Health needs to play to be supporting the HHSs in that workforce strategy? The frustration that we heard travelling around is that everyone is doing the best they can in Queensland Health. It is not to say that the HHSs are not doing everything in their power, but they are in a really tricky place at the moment trying to compete to attract specialist services into regions.

The second part of my question, which is for your colleagues, is: how best can we leverage the expertise in Metro North, Metro South and other metropolitan areas where there are specialists and expertise, whether that be in a hub-and-spoke model, or what is the collaboration that is already occurring, or is there opportunity for that collaboration until workforce planning is properly addressed?

Prof. Allan: Thank you. There is a lot in your question.

Ms CAMM: It is a big issue.

Prof. Allan: There are specialist adolescent beds in Townsville. Our next plan will look to increase, if we were funded, the number of specialist adolescent beds along that coastline because we recognise that is a particular issue. I also point out that I have spent 20 years working in Townsville and I know the issues about recruitment—and I will say a little bit about that—and have been to

Mount Isa many times and did what you were asking then to do, which was to go from Townsville and do the clinical work in Mount Isa, Doomadgee and Mornington which I thoroughly enjoyed once I got there. That is something we can—

Ms CAMM: I wish there were more of you, Dr Allan.

Prof. Allan: I have not done it for a while. One of the things we did in Townsville which was really important was set out to create a critical mass. We actually decided that we needed to show leadership to get the people around us. I do not want to make this about what we did, but when I went there in 1989 there were 20 people in the mental health service. When I left there in 2009 there were 420 people. We went from two psychiatrists to 22. Now they have 40 and they still do not have enough. Demand, demand, demand is really problematic.

What we have set out to do is, one, make it a centre that would attract people by training, research and collaboration. We set up the first regional training program for psychiatrists, and the professor there, Professor James, had been president of the college. I joined the training committee. We promised people we would get them trained in psychiatry. We trained all the psychiatrists in Mackay and Cairns as well. We need to set up those kinds of training and support initiatives. That is what we can do with our plan.

These days there is a lot of competition. We already have that kind of regional hubbing effect and support and do all of those things, but it is very difficult. We do not have the capacity of differentiation in terms of housing and supports. We have a little bit of differential at play in Townsville—five per cent more in the private practice alliance, 15 per cent more I think or 10 per cent in Mount Isa but not very much. We do not have all those other incentives so it is always a challenge to do all of those things and it would be good.

The most important thing is to make the work safe, exciting and good. That is what we set out to do. If you feel like you are doing good in the community, you will do well there. If you feel like you are continually under pressure and chasing your tail and no-one cares, then of course it would not matter how much money we offered to people. We have to have a system that supports. I think the various leaders in those places work hard to do that, but, as you say, there is pressure on them because it is just so hard and the pandemic has made it very difficult.

A lot of the recruitment was overseas doctors. One of the things we specialised in was helping overseas doctors get their Australian qualification. We specialised in getting overseas nurses, like Kieran here and others, to come and show them what a good time they can have by coming to work with us. That has dried up a bit in the pandemic so we need to grow our own as well. We need to work with universities and have the training scheme from zero to 100 from the beginning. We work with universities like James Cook, CQU and so on to make a difference in that as well. There were a lot more parts to your question. I cannot remember them all. I had better let my colleagues speak.

Mr Kinsella: Before I talk on collaboration I want to mention the workforce as well. We struggle in Metro South as well to recruit and fill our positions. We are running with a reasonable number of vacancies at the moment and continually advertise to try to recruit in. We have a net loss rather than a net gain in staff. When we look at our monthly leavers and starters, the number is not high—it is about three and four each month—but that accumulates over time. Feedback that we get from our staff who leave, which is quite often our senior OTs, psychologists and our consultant psychiatrists, is that the work is so pressured that it is easier for them to go to the private sector and work in the private sector where they can control who they see and can control how hard they work. It is worth saying that because it is a pressure for us.

In terms of collaboration, there is a lot that happens. We outreach to Roma. Our older persons consultant today is out in Roma and doing clinics out there with them. We have a contract with the South West HHS to provide that. The mental health branch coordinates a lot of clinical collaboratives across the state. We have the opportunity as a statewide network to get together as senior clinicians to work on specific areas. We have worked on care planning, we have worked on risk assessment and there is another collaboration that is just about to launch. We do get to share the good work—not just what happens in metros, because an amazing amount of work happens out rurally. I worked up in Central Queensland before I came down to Metro South. The amount of work that a rural and regional area can do, both in collaboration with partners and with the resources they have, would blow you away in terms of what they achieve. We all learn from each other in terms of that.

We also in Metro South provide an adolescent service to the south-east of Queensland. I am the metro and local adviser to Central Queensland. We will work with those regions as well by upskilling their staff. Separately to all of that, within Metro South we are working with the broader sector, too. We had some discretionary funding for a COVID response last year and we worked with

our PHN about how we could best implement that. One of the things we have started to do, and have been doing now for 14 months, is training NGOs and primary care on DBT. We have a competency framework and we have been working on bringing our HHS staff, our primary care staff and our NGOs together to learn together in our competency framework. We obviously get the benefits of consumers who can get access to whatever is best therapy but we also get the benefit of our sector working together and learning together, which enriches the services that we provide.

Dr Turner: The other thing I would say is that it is incredibly challenging when we have temporary positions and temporary funding that lurches from year to year. What we need is a five-year plan where we know exactly what funding we are going to be able to get. As well as all of these things, we need to grow our own. We need to develop and have a clear, comprehensive workforce strategy.

Mrs McMAHON: Professor Allan, I wanted to ask about the crisis support spaces. I understand there is a crisis stabilisation facility that has opened at the Gold Coast. I wonder if you could elaborate on the evaluation of those facilities and what kind of funding you think would be needed to roll out something like that in other parts of the state.

Prof. Allan: We are planning in our next plan to roll out more of those crisis support spaces and we are planning to look at the unit at the Gold Coast as a model for that. I might actually hand that question to Dr Turner, who opened that Gold Coast unit and has evaluated it. I think she is better to answer.

Dr Turner: I think it is important to see the difference between crisis support spaces—for example, the ones that are in the community—and the crisis stabilisation unit. The other thing is that none of this is the answer. We did a lot of work on the Gold Coast around regional planning. We developed a regional crisis response plan. We worked very closely with Police and Ambulance, the PHN, a whole lot of NGOs, our emergency department et cetera. We know that there is an increasing number of mental health patients coming to emergency departments and for many people it is a terrible experience. The crisis stabilisation unit is an opportunity to have a true alternative to the emergency department. What we need is lots of other options like crisis safe spaces. What we need is more funding to be able to do assertive crisis response for mental health, and a peer worker model would be great if we had that ability—ideally, as much in the community as possible.

For those people who do require a facility, who do need to come in, the crisis stabilisation unit is an alternative to the emergency department. It is a very clinical model but it is a peer first, peer last. You are met at the door by someone with lived experience and a clinician together. As you leave, your interaction is with a lived experience person as well. We have had—it is not 'we' anymore because I am not at the Gold Coast—fantastic feedback from consumers about a completely changed experience compared to the traumatic experience they had before. That will have a whole lot of ripple effects.

The evaluation that I have been able to see so far is that they have had a significant reduction in the number of people who go to the emergency department and the time spent in the emergency department, so it is achieving that goal. We particularly chose to place it near an emergency department because you do need that relationship and that ease of flow so that if someone really does need an emergency department for medical reasons—once that is past you can ideally move them to the crisis stabilisation unit as quickly as possible. The model is an up-to-24-hour crisis stabilisation unit and then a short-stay pathway, short-stay beds—eight beds that ideally people can go into for up to 72 hours. It is about providing interventions and actually resolving some of the issues. In terms of the short-stay pathway, we published some information about a pathway before we had the unit and we were able to demonstrate that for a matched group of people the length of stay went from about 7.9 down to 3.3 and they had a 42 per cent reduction in re-presentations. It is about providing people with care and interventions and that is what we have to do more of.

Mr O'ROURKE: My question is with regard to place based solutions for clients and the formal commitment of those who are involved in that process. Prior to being in politics I worked in the housing and homelessness area. I worked very closely with mental health services in Central Queensland. We found that we would get a housing solution for someone, they would then become unwell and then we would have to try to get the support before the damage is done in the community, whether that is in a privately owned dwelling or government owned dwelling. Is there anything around prevention and getting in early, before someone becomes very unwell and causes issues within a community?

Mr Kinsella: Our strategy within the Brisbane South PHN has all been about improving the wellbeing of the community and trying to stop the flow of people becoming seriously unwell and needing our services. We both stood up as leaders within the system and said we need to work

together to make this difference. In terms of the commitment, we made that right at the very beginning. We committed to try to do things differently to how we have always done it. The DBT education I just described is an example of that, where we committed some funding and the PHN match-funded it and we got a good service delivery. Where I think we struggle a bit is having that discretionary funding. It is not often that we get funding, particularly that we get funding that is recurring, where we can locally decide, with the PHN and with our local providers in the community, how we are going to spend that money. The money that we get needs to provide specialist services and there is a gap and it needs to be committed to that, but it does sometimes prevent our ability to do that place based kind of work. We influence and work with the PHN around their pot of money, but they equally have similar restrictions around how their money is given to them.

Prof. Allan: Similarly, we work with other departments like housing. There is the homelessness strategy, of course, and you are aware of that. It is sometimes difficult for both to bring pots of money to the table at the same time, which is what you are talking about, so we need to be more coordinated. Housing is a good example. We are working with them on that strategy but also the same thing in youth services and so on. The place based strategy is particularly important when we want to stop people graduating out of that difficult space into the stuck-in-hospital type space. Our system works on the idea that all of our beds and services are used by people who actually need that service at that time. When we start to get things silted up with people who are stuck somewhere then there is not the flow of services that the people you are talking about need, and that is a problem.

CHAIR: Is that an issue that relates to the fact that we do not necessarily have well-connected government services? While someone is utilising Queensland Health services in whatever capacity they get some good help and then they stop. Then they are suddenly in housing or they might be engaging with the justice department; they might be in prison. Do we actually need some sort of community based case management for people who are engaging with community services?

Prof. Allan: We often do in those situations work with Justice. We do it with Housing and so on to have that. I think the issue is that everybody is busy and there is not enough pie to go around. When we have worked on those things, for example people coming out of prison and so on—we have that linked-up stuff—it is good, but we can always have more. I do not think there is a lack of will. I think there is a lack of time and resource. Certainly that is a big part of how it should work.

CHAIR: The care, though, seems to follow the department rather than the individual and the individual can often get lost to the department.

Prof. Allan: They can get lost. I think that is true. It is a compromise between having that linked-up care with providers—we talked about the NDIS example of things not being linked up because nobody knows that the NDIS does not link up to those care providers. People fall through the gaps, too. We need to find a position between those two; you are absolutely right.

Mr MILLAR: As many of you know, the seat of Gregory is in Western Queensland, so you will get an idea of what I am going to ask you. How many mental health beds are available for patients at the Emerald Hospital?

Prof. Allan: There are no specific beds for mental health patients at the Emerald hospital. There are general beds.

Mr MILLAR: What is the procedure if a patient turns up with an acute mental illness? What happens?

Mr Kinsella: Most people who come in crisis will go through ED. That is where they will get their support. In Emerald—I used to work up there—there is a community mental health team that provides inreach to the ED. Outside core hours there is an acute response team which is based in Rockhampton that provides telehealth support.

Mr MILLAR: I am talking about an acute mental health illness requiring hospitalisation and treatment. What happens to those patients once they present themselves at the ED?

Mr Kinsella: They will be assessed by the mental health team to determine whether treatment is required, how acute it is and what the level of risk is. People eventually would have to be transferred to Rockhampton.

Mr MILLAR: That is what I was getting at: we do not have any mental health beds in Emerald. Emerald has a population of 15,000. The shire is 35,000. If Emerald does not have any mental health beds, I suggest we would have similar problems in Longreach and other areas in my electorate. What do we need to do to try and fix this problem?

Prof. Allan: The planning framework helps us look at these regional beds. I think I have told Mr Katter so it is probably okay to say this: we would plan to trial some beds in Mount Isa. We are trying to look at a model and trying to work out that model of what we could do. Then we would hope

that that is something we could look at, work out the way it would work and then move on to others in the next phase of our plan. I will give some examples. When I worked in New South Wales there were some regional beds in Broken Hill. They started off with a pod, which was one or two beds in the general hospital. They have actually moved that on to I think four acute beds and six rehab beds. We would look at some kind of hybrid model like that in Mount Isa and start to think about how we get that into the general population.

At one time in my previous life in Queensland Health I went to Longreach Hospital and made an assessment of the hospital after there was a very tragic suicide there. I looked at what the possibilities were. At that stage it did not go ahead, but I think we need to re-look at that problem. I have a few issues with it. One is that when you open up something like that you need specialist staff to be able to come in. You need people who are trained and able to do things. Earlier I was talking about absconding and not having a tragedy on your watch. There are things about how you would staff, run and manage, but telehealth has made a difference to us in terms of assessing people. It certainly makes a big difference in terms of the people who need to be transported or do not need to be transported. We have a lot of opportunity to change that.

Mr MILLAR: I am looking forward to working with you to see if we can get this up and running, because we desperately need it.

Prof. Allan: I agree.

Ms BUSH: In terms of place based initiatives, a lot of reviews that have been undertaken, DV death reviews or whatever, would indicate that one of the issues working departmentally is information sharing. Often multiple agencies are 'touching' the same person, but the risk appetite of the agency will only allow them to share information once risk has been established, not to establish risk. Have you done any analysis within Queensland Health around your risk appetite? What needs to change to support information sharing, because funding is one thing but information is another? Would that require a cultural change or some legislative amendments to support you to do that?

Prof. Allan: There are probably some legislative amendments needed. My experience in working in the past seven years in the central bit of Queensland Health is that we have been quite open to sharing data which is called on the clinical need. We find it easy to share with people who are providing care and health care. We have a lot of arrangements with GPs and a number of NGOs, and we are opening up our system to other NGO partners. We are looking to do that all the time.

In terms of working with other government departments, there are often issues for them around sharing. For example, Child Safety, as you know, has probably the hardest sharing rules. At the level that I work at there has been a lot of goodwill in terms of memoranda of understanding. We have one with Prisons, one with Child Safety—one with everybody. I think we could do a lot more to do that.

I also notice—I am sure it is part of your point—that death reviews, domestic and family violence and child safety reviews still tend to be done in isolation and not using all of the information available. Having been a Health representative on a number of those committees, I say, 'We have the data. Why aren't we looking at this before it happens?' We probably need to change practice and legislation. I am not sure that we have to change intent. I think people want to have that intent.

CHAIR: Thank you. I thank you for your evidence today. You have not taken any questions on notice. We are out of time, but if members have further questions they may put them to you on notice via the secretariat. Thank you for your time and your appearance here today.

Prof. Allan: Thank you very much.

CALLAGHAN, Ms Amelia, Executive Director, Queensland Mental Health Commission

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

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

CHAIR: Welcome. Would you like to make an opening statement?

Mr Frkovic: Good morning, and thank you for this opportunity to speak to you again—I have attended as many hearings as I can live and been here in the audience, but I have also watched most of them online because we as the commission and I as the commissioner are really interested in this process—and to confirm and reconfirm some of the issues we keep hearing across the state about what is needed in terms of mental health reform. It was a great opportunity to be part of this process.

I acknowledge the traditional owners of the various lands on which we meet and pay my respects to elders past, present and emerging. I also take this opportunity—we do not get too many opportunities to do this—to thank the broader mental health and alcohol and other drugs workforce for their professionalism and dedication, particularly during this pandemic and recent natural disasters. I think they have done a phenomenal job and I would like to publicly acknowledge them here.

Over the past few months you have heard from many people across Queensland and the country, including people with lived experience, their families and carers but also sector leaders, service providers and peak body representatives. As members of this committee you have heard a full account of the many issues and challenges that Queenslanders experience. They report a system that is fragmented and hard to access even when in crisis or in acute need—a system that at times is not willing to listen to their needs or involve their families and carers, a system that works in isolation, leading to people being bounced around services only to receive supports for limited periods of time and only available, as we have heard, in some areas but also with long wait times.

As my colleagues from Health have said, particularly the public mental health system is buckling under increased demand—but so are the other parts of the system. It is not only struggling to retain its workforce, as we have heard, but also struggling to entice and attract new staff. You have also heard suggestions for what some of the solutions could be. These include: meaningful engagement with and leadership by people with lived experience, families and carers; prioritising mental health promotion to reduce stigma but also to encourage, as again the committee has asked about, early help-seeking behaviour; and increasing the system capacity to intervene early in life, early in vulnerability and early in illness but also early in the episode.

You have also heard about strengthening integration and coordination across public, private and NGO service delivery, within Health but also across and beyond Health. You have heard about developing effective responses to people who may be at high risk. We have just had that discussion. You have also heard, even in some of the discussions from the Victorians, about the need to rebalance the system towards community based treatment, care and support whilst also ensuring, as my colleagues from Health have said, that a range of bed based services are available and accessible to those people who need them. Finally, we can also see from the various submissions and witness statements that drawing on the positive mental health outcomes that come from stable housing, education, employment, social participation and connection is critical. Over the past few months the committee has also been provided with many examples of great work, and we have heard some of that—pockets of excellence and innovation that could be upscaled and developed further. We have had discussions around the crisis stabilisation unit at the Gold Coast as one example.

I have been impressed by the committee's engagement and commitment, the level of questioning and the seeking of additional information from the community but also from the broader sector. However, you now face the challenging task of formulating a report that captures what you have heard and provides recommendations for government and system consideration. I suggest that the solutions that have been identified through this process have also been identified in numerous other reports and inquiries including, for example, the recent national Productivity Commission report into mental health. The challenge, however, is one of implementation and scale, including securing commitment to sustained change across whole of government and appropriate ongoing funding to deliver against a vision that meets demand but also people's and community's need.

In my opinion, it is not the time to focus on components of the system but, rather, the system as a whole. We need to strengthen the authorising and enabling environments to address the issues of complex funding arrangements, which you have heard; to tackle silos, gaps and duplication; to

drive whole-of-government approaches; and to joining up policy and planning, funding and commissioning implementation but monitoring, reporting and accountability. Importantly, we need to strengthen whole-of-system governance and leadership, including the leadership of First Nations people both within commissions and the commission here but also more broadly across government. We need to increase access to considerable and sustained investment in mental health but also the alcohol and other drugs sector. We need to endorse a renewed approach to the way we deal with alcohol and other drugs in Queensland with a particular focus on diversion. Growing, developing and sustaining our workforce, including the peer workforce, is critical if we are to achieve any of that.

Before I conclude my opening statement I appeal to this committee: in finalising your report or recommendations, bipartisanship is required. Bipartisanship will provide the best opportunity for implementation of your report recommendations and achieve the reforms required in mental health and the alcohol and other drugs system in Queensland. After all, people with lived experience of mental ill health or problematic alcohol and other drug use and their families and carers require and deserve this from this inquiry. Thank you.

CHAIR: We thought we had a tough enough job just trying to reform the mental health system. Now you want to us to do it bipartisan! You like to really throw us a challenge! Can we start at the planning stage? You alluded to the many other reports and inquiries that have been held. The committee has heard varying views around the process of planning at a more localised or regional level. Certainly we heard from community controlled Indigenous health organisations on their views, particularly in discrete Indigenous communities. What would be the commission's view in relation to the ideal or optimum model going forward around regionalised planning?

Mr Frkovic: Can I put regionalised planning in a bit of a context and answer that directly. If you think about the way we are currently working, with all its challenges and opportunities—for example, we as the commission are usually engaged by the government of the day to help the government set the strategic direction of where we are going with mental health, drugs and alcohol or suicide prevention. That is more of a directional document. Then agencies such as Queensland Health—and the plan that John talked about—have agency-wide operational plans: how many beds does Health need, what does Child Safety need, what do Corrections need et cetera? That should then influence also the local planning that should occur at the local level among HHSs, PHNs, NGOs, the private sector, obviously people with lived experience and other sectors—we talked about housing, unemployment and so on: how do we get that to happen?

Picking up on some of the points made by my colleagues from Health, we have gone a fair way down this path. I do not think we are at the stage we need to be, but I think there are some HHSs and PHNs that are doing some fairly sophisticated work in this space. I think what is missing—and the Victorians are talking about it—is having at some level a broad responsibility for that to happen. I am sure the two HHSs we have around the table work very well, but we need some sort of clear direction, some authorising environment for that local planning to occur. It needs to be something that is requested. It needs to happen. I think that is why the Victorians—picking up John's point—have gone through boards that will have clear authority to do certain things, because they had a bit of a mish-mash of a system, if I can use that term, prior to this. I do not think we are there. I think John is right: I think we are further down the track, but we need some clear governance.

There was also a point made by Queensland Health that it is hard to plan locally. What you need in Metro North will be different to what you need in Central West, for example, but your money is always tied. When I talk to the PHNs, the public system or the HHSs they say, 'No, I've only got money for 10 FTEs. I've got money for these beds.' The PHNs say, 'No, they've just given us money for this type of suicide prevention way back.' Picking up on your point, there is no flexibility to say, 'In our community this is how we would like to address this mental health issue in a flexible way.' We need to formalise those governance arrangements and decision-making and authorising environments at the local level but also give them a chance to make decisions particularly around how new money is spent, whether it is Central Queensland, Central West, Far North or in the larger metropolitan areas.

CHAIR: What you are effectively saying is that, again, it comes down to the autonomy of the HHSs. If they choose to do it they can, but there is no obligation on HHSs to be engaged in a process of regional planning around mental health services beyond their own offering as acute and rehab services in crisis care.

Mr Frkovic: I think it is alluded to—my colleagues from Health are probably in a better position to answer this—in their service level agreements they get from Queensland Health with funding, but you are not compelled to do this. It is all done because we have some great leadership in mental health who work with the PHNs quite well. All I am saying is that that needs to be a formalised

governance arrangement and a requirement, and that needs to be supported by a level of flexibility of funding so those people in actual fact can make local decisions on how to expend those dollars based on their local needs.

CHAIR: I presume you have read the *Bilateral Schedule on Mental Health and Suicide Prevention*. Does it have any impact on the issues we are discussing here?

Mr Frkovic: It potentially does. I have been asked to provide commentary on this. In terms of what John was talking about, the quantum of dollars is minimal for what we need, but can I say that the emphasis is right. The emphasis on where the money is going is right. The federal government offering of only five Head to Health services for Queensland is nowhere near what we need. The Victorians, in addition to the 15 that the federal government gave them, are building an extra 60 from their own money. That is Victoria; look at their geography. As you have discussed with my colleagues here, those centres are not going to be the answer to all of our problems, but they are certainly a phenomenal start to get people in early. I think the comment was made earlier that we need to get people into services early where they are not going to be told, 'Sorry, your diagnosis is not right. You're not severe enough. You should go and see a GP.' It is really about that new, broad front door where you can go and present and look for some help and support without being excluded because you are not severe enough or you are too severe.

Ms CAMM: This is a follow-up to the chair's question around the need to formalise or provide local planning authorities with governance framework and responsibility. Whom do you see as leading that, if the committee were to make a recommendation around local leadership and local boards similar to a Victorian model? Do you see the commission as setting that strategic direction, those frameworks and measuring that? Whom do you see as leading that work or those recommendations or those frameworks to empower local boards?

Mr Frkovic: From a commission perspective, we would certainly see our role as supporting the establishment of that governance arrangement, formalising it. I think there is a governance arrangement; it is more the formalising of that, and part of our role would be to do that as stewards of the whole mental health system across public, private, NGO, Commonwealth, state et cetera. Where our role would probably sit better, based on where we are, is around monitoring and reporting on how that is going. They are the bits that, from more of an independent perspective, provide some of that greater insight, rather than being enmeshed in the actual mechanism itself. We would support the establishment of that. There would be no doubt we would see our role as supporting that.

Ms CAMM: Subsequent to that, do you see evidence based best practice or the measuring of that as needing independent leadership? You have PHNs at a federal level, Queensland Health has its own vested interests as HHSs individually, but there is also local government, other NGOs and the not-for-profit sector. Do you think it should be a completely independent subset of government or some special task force that is set up?

Mr Frkovic: The Productivity Commission recommended establishing these independent regional commissioning boards particularly in places where that PHN-HHS relationship is not working. That could potentially be something. Can I make a general statement here? From my understanding of the linking of PHNs and HHSs, I think we are doing relatively well in that space. There are probably a couple of locations where we could do better. I think there is some movement in the right direction.

What I was trying to say—and I think I am trying to reiterate again—is that these things are happening more so because of the people who are leading and trying to make this happen than a formal arrangement. The Victorians, I think, are moving to a formal arrangement to say, 'We will have these boards.' I am not that convinced around some of the stuff in Victoria because they are early on in the piece as well. As John indicated, they are trying to fix a much more complex array of arrangements that they had prior to this. I think we are further down the track, and I think we could just formalise those arrangements at the local level. As a commission, based on our role and our function, we could provide some of that oversight, reporting and accountability mechanism to report on how things are going. We would do some of that. That would be certainly within our remit.

Mrs McMAHON: Thank you for the detailed list of recommendations all laid out nicely for us—all 77 of them. There are two things I wanted to have a look at and tease out a little bit more, because I do not know how much we really focused on it when we last had you here. I know that you have heard and been listening to some of the evidence given so far. I just wanted your thoughts on this. There were many recommendations and submissions around oversight, particularly parliamentary oversight and performance. Usually as a parliament we do this through the budget and estimates processes. I am just wondering how we as a parliament can best spend our time, either through an

estimates or other process, really evaluating the spend on mental health within the Queensland Health budget and looking at the outcomes we are achieving for that, with a particular focus on mental health.

Mr Frkovic: From a parliament perspective rather than just the government—

Mrs McMAHON: In terms of deciding where the money gets spent.

Mr Frkovic: Yes. Just listening to that question, I would not mind taking it on notice if I can, because I think there is some sort of unpacking of some of the existing processes that we have in place.

If I can take us back probably 12 months to two years ago, the government had a process in place called Advancing Queensland's Priorities, if you recall. I was very supportive of the priorities, obviously, but I was really supportive of some of the governance arrangements. What was really useful in that process was that you had the minister who was responsible for that area—for example, keeping Queenslanders safe was one of those, or giving every Queensland kid the best start, phenomenal things, employment or whatever it was, health and rates of suicide et cetera. For example, the minister at the time who was my minister at the time oversaw what was called a ministerial oversight group. There was a whole range of ministers who were overseeing this, and then you had a structure underneath it—which I think we put into our submission—which had a group of departmental people, senior people at the director-general and deputy director-general level, who were then working on that process, and then there were other groups underneath, obviously. From my perspective as a commissioner and working through those groups, that provided the best structure I have seen so far in terms of accountability, achieving certain things and people having to report why things have or have not been achieved.

In my own experience working with all of those groups—and being somewhat external to the bureaucracy, I was involved in some of those groups—I think that is where we got the most traction and we actually moved things on. It was great to have the ministers and the senior bureaucracy but also some of the really operational people all lining up. I am suggesting that that gives—at least from my experience—a useful way to enhance accountability. Just picking up your point, within a government framework, how do we ensure there is the accountability back to the broader parliament, as you say, around mental health spend and how the reform is going? Are we achieving what we set out to do and, if we are not, why not? Let's call it out.

Mrs McMAHON: The other thing I wanted to look at in terms of levels of government is that there are a lot of recommendations that call on the federal government to make some amendments around a number of things and obviously the state government as service deliverers. We have heard from various representatives at the local government level about the role local governments play within the mental health space. Given the parliament's recent inquiry into social isolation and some of your recommendations, are there any recommendations that you see would almost neatly fit into that local government space within the proactive and community wellbeing area? Are there any examples of programs you have seen delivered by local governments that could be called anything but, in effect, are having a positive mental health outcome on communities?

Mr Frkovic: I think local government plays an important role in mental health. It has not historically, but I think more recently we are seeing local government play an important role. It is around more of that local infrastructure community stuff, social connection, common space and parks. Even the design of communities is really critical around positive mental health versus a siloed, isolated community. I think they play such a crucial role. My colleagues in Health and I worked really hard when the Queensland government made an investment around the economic recovery plan. We also then certainly advocated very strongly.

As I said previously in my witness statement, I think Queensland probably did the best out of all the other jurisdictions in terms of recognising how important mental health is in terms of economic recovery or human and social recovery. As I talked about, mental health was a component. Victorians have given a lot of money after all of this, but what the Queensland government did at the time was give money for economic recovery to do with mental health. Money went to the non-government sector, drug and alcohol services, the public system et cetera. Within that there were also funds that went to local government.

John and I worked really hard. I cannot remember the figures off the top of my head; I can provide that to you. Some funding went to a whole range of local governments to look at some of those broader community activities that will help people to maintain wellness—participate, break down social isolation—because it is such a critical aspect of the recovery process. To take that one step further down, we are currently working with the Mentally Healthy City project in Townsville. The Townsville City Council, us and a whole range of other players are involved in looking at what a

mentally healthy city looks like and what we need to do to drive that. In fact, I have already had discussions with some other councils about the learnings from Townsville and what we could share to take to other local government areas for them to pick up some of that.

Mr MOLHOEK: Commissioner, I have enjoyed reading through your last submission and the 77 recommendations. Having travelled around the state and heard from so many people, it has been something of a surprise to understand how many different aspects or facets there are to issues around mental health. We have heard from some fairly interesting groups around issues that I had never considered prior to this inquiry. I feel as if I could be forgiven for thinking that everyone has a mental health issue. In your submission, at page 37, you talk about shifting to wellbeing. Do we need to change some of the language around issues of mental health? Are we putting too many labels on issues that are perhaps just normal aspects of life in terms of anxiety or episodic events that occur?

In Hervey Bay they are running a program called Shatter the Stigma. Earlier this morning we heard from Victoria about the mental health and wellbeing hubs. How do we de-escalate the issue—and I am not suggesting we ignore it or do not address it. At the risk of sounding like a dinosaur, do we need to bring back Norm from the seventies to explain to people what normal life things are and how to face life? I am not suggesting that he is an appropriate role model in our current era, but he is the only example I could think of.

Mr Frkovic: I have certainly strongly spoken about the risks with pathologising some pretty normal human behaviour. I am going to disclose something to you here that I do not normally talk about. I lost my dad six months ago and I lost my father-in-law a month ago. In six months I lost two really important people in my life. You feel it psychologically. I do not think I am probably at the state that I need to be. I certainly do not need John's assistance as a psychiatrist—thank God—but you are in a phase where you do realise that things are not quite right. You do need some assistance. You do need to talk to somebody. You need to do some things that you normally do not do in terms of your own mental health et cetera. I would not want to pathologise what I am feeling, but clearly there might be a stage in my grief and recovery journey when I may need to access some—if I can use the word more broadly—formal supports by talking to somebody about some of these issues. I am not going to the extreme end at this stage—I do not feel I am there; I am a long way away—but you want to work through some of these issues that are normal reactions.

I do not think we should be trying to pathologise normal human reaction to abnormal situations that we experience, but if that is prolonged and I cannot manage my life and I cannot move on with a whole range of other things then you start to think, 'How do I get some of that support to be able to do that?' We have to think about how there are things in our society that are going to put pressure on us every day. I can tell you that even being here before your committee puts pressure on me as well, in preparing et cetera.

Mr MOLHOEK: It does on us, too.

Mr Frkovic: We talk about resilience, what we have, how we manage with this, how we deal with these issues et cetera. I think these are really complex situations but my view is that that is why we are pushing the whole system down rather than up. I think the discussion you have heard and seen is that when you look at the data a small number of people need that severe end of the spectrum. Most of us sit somewhere here and we will experience some life stress and distress. That is what I liked about the national partnership agreement. It is a very small amount of money, but they are actually suggesting that, jointly with the state, they will fund distress brief intervention for people who may be on that journey of thinking about whether life is worthwhile. They are not at any severe stage, but they can actually go and talk to someone about their distress. I think we are seeing now the system recognise that and we are starting to build some infrastructure to respond to people who are vulnerable and who are in the mild or moderate stage. Clearly we already have a need to meet more of the demand for the severe, but I think the biggest group is here. That is all of us, in some way. In different phases of our lives we are all going to go through that.

Mr MOLHOEK: One of the groups that we heard evidence from—I am trying to think who it was—basically suggested that the vast majority of people who seek mental help, say, from a counsellor or psychologist, on average need only about 1.7 appointments. So if you get the right person then you just want someone to talk to, to set a few things straight and work it out. We have heard a lot of dialogue that Medicare should increase the number of mental health appointments from 10 to 20. I would be interested in a reflection on that. Is it about quantity or quality?

Mr Frkovic: In our previous lives my colleague and I used to run a lot of headspaces. On average, from my recollection—and you might recall, Amelia—at the time of the 10 sessions that a young person had, on average, 4.6 or 4.7 sessions were taken, not the 10. I do not think we should

have a fast and hard rule about whether it is five sessions two, seven or 10. I think it is about my needs being different to your needs or somebody else's needs. This is going back to the earlier point around flexibility in the system. As a clinician, if I need 13 sessions then that is okay but if my colleague here needs two then that is okay as well. We have to provide that flexibility. We have these fast and hard rules: if you fit into this box then you can get this many and that is all you can have. I think we have to move away from that.

The other question is about wellbeing. I wanted to pick this up because you raised it earlier. My colleague from the college of psychiatry who was here made a very good point and it is something that we have to keep in mind. Wellbeing is a broad concept. The public mental health system, as he was talking about at the time, is about illness and the severe end of the spectrum. It is not that there is not a wellness component to that, but I think his comments were—and I want to reiterate that—that you cannot expect the public mental health system, which is about the treatment of severe illness, to also have a wellness focus. They will do elements of wellness within what they do; there is no doubt. You have probably heard from my colleagues from the Queensland Alliance for Mental Health and the drug and alcohol sector et cetera. The wellness component is about how you keep people well—how you look at other life needs, look at their strengths, look at what they offer rather than the symptoms of their illness. I think it is about: how do I live well with my illness, how do I have secure housing, how do I get myself a job, how do I get my children back? Those are the wellness aspects that we all expect. People with mental health particularly will also want the same.

Ms KING: Commissioner, can you speak a little about data and reporting? As we consider large investments into the mental health system hypothetically, how do we make sure we are getting the data from across the system that will drive the very best outcomes? I note that in your submission you state—

The lack of detailed data made available in Commonwealth reporting limits the extent to which large funding bundles can be mapped to services on the ground ...

That is a just small snippet of a small issue.

Mr Frkovic: Of course.

Ms KING: I do not doubt that those same kinds of issues may be reflected elsewhere in the system. Can you speak to us about where reporting is good, where and how it needs to be improved and what we should be measuring in order to ensure the very best outcomes in an enhanced mental health system?

Mr Frkovic: I was really pleased with your opening statement—that felt good—about potentially some funding for mental health.

Ms KING: It is not me who makes the decisions.

Mr Frkovic: That is right. I understand the processes of both federal and state to a relatively good degree, although probably more around the state. I think there is a problem in that when new money comes in we are probably good at collecting some of the data in the early phases, whether it is client outcome data, system data, rates of readmission and all of those things; however, once that becomes part of core budgets—whether it is government, non-government et cetera—we go to a fairly generic reporting requirement. This is my personal opinion, and my colleagues from Health can probably add to it. I would like to see much greater detail, for example when it comes to the public system, in the contracts, the service agreements, between Queensland Health and the HHSs around the mental health dollars. I would like to see more detail about what the money is about and the reporting requirements. I know there are some standard requirements and my colleagues—John and others—can talk more to those: seven-day readmissions and, yes, consumer survey feedback. We do get some of that general data. But if we are to drive reform, you need the data to give you an indication that we are going down the right path.

People have asked us, and I am sure you have had other people mention to you, about the role of the commission. The commission really gets the data that is in the public domain, like you all do, whether it is the RoGS, the AIHW et cetera. I do not have any authority to get that sort of detailed data to say what was allocated to Metro North, how that money was spent and whether it achieved what the government had particularly intended. I do not get that level of granularity or detail, so who is doing that?

For example, in Western Australia they have a commissioning commission. There are all the challenges with a commissioning commission, and I am not advocating that; I am just saying that that is their option. The one advantage is that they fund health and they fund the NGOs, but they have much stricter reporting data collection criteria to actually say, 'What has been achieved? Has this been expended in the right way? What client outcomes have we seen?' I am seeing more of that

developing in some of those states, but we do not have that as detailed, for example, in Queensland Health. The federal government is probably the same, as far as I know, in terms of the money that goes to the PHNs and the reporting that is required back up the line. The problem is that the money is tied, as I think my colleagues have said, and they do not have a lot of flexibility to do what they need to do locally. Even with that, we do not have enough reporting to understand what has happened. That would be my opinion from where I sit. John and others might have different views, but that is certainly from where I sit.

Ms KING: To your knowledge, are there any jurisdictions that use that sort of continuous quality improvement approach of monitoring data on an ongoing basis, not just setting up a trial or a pilot program and seeing outcomes and then funding on an ongoing basis because it seems good for that 18-month to two-year period? Is there any jurisdiction, to your knowledge, that does this very well?

Mr Frkovic: My general answer would be no. We have a Westminster system and it starts from that sort of process and how things are funded. There have been some useful things historically with some of the LHDs, or HHSs as we call them here. We are much firmer around some of that sort of thing and also the central agency held them more accountable, but that wanes over time. Again, I am not blaming the HHSs or central office; all I am saying is that that is the process we are in.

For example, if I was sitting in a HHS chair I would want less specificity in my contract so I can do what is important for me here, but a central agency—for someone who is looking at the system externally, or even parliament and ministers—wants to know the details. For example, if the government makes a huge investment, have we achieved what we said we were going to achieve? Does the data show that? Those are the sorts of things. Again, John has been around probably a little longer than I have, but my general comment is that I have not seen any perfect system around that in Australia and, I have to say, not even overseas.

Mr MILLAR: Thank you so much for coming in and for the work that you do. It is very important. I want to go back to a question I asked earlier in the session: what do we need to do to provide the mental health beds and the facilities and the capabilities in Western Queensland?

Mr Frkovic: It was good that I could sit and listen and now add to what John and the other colleagues have said. There are a couple of things. I think part of the answer is that we have to get out of the frame of thinking what the definition of the bed is. I think we need to start there. I have seen other countries and other jurisdictions that provide beds in very different ways that are not in hospitals and support people. That is the innovation stuff that you have all been talking about and you have heard about. How do we, for example, provide some beds in your location that are not even hospital beds but they provide a level of care where someone can stay and be supported for the period of time that they need? How do we then also, in addition to providing some beds but different beds, do things like—and we are pretty good at this, but we need to do more of this, and I think John started to touch on this—hospital in the home? A bed in its own right is not going to be the answer to my acute phase. It is the support that I get. If we could use your bed and provide the level of intensive support that you need—hospital in the home—we might be able to deal with you much better in the home than by putting you in a bed. If you talk to consumers and carers, they would tell you that one of the most traumatic experiences they have had was an admission to an acute inpatient bed.

Mr MILLAR: To give you an understanding of what we are facing out in my part of the world, I know of someone who had a child who needed a mental health plan and they had to wait 14 weeks to see a GP. They are some of the issues that we are struggling with at the moment in Western Queensland. I am not asking for a quick fix, but is there planning underway? Is there an understanding of what we are facing in these isolated rural and remote areas?

Mr Frkovic: From a Health perspective my colleagues are doing a lot of planning, and I think they have all of these issues within their purview and what they can do. We are also pushing other agencies and other government departments to think about how they contribute to some of that community bed stuff that could be done. We have some examples. For example, we provide youth community therapeutic services for four to five complex young people in a community context—in a house in a street—which is staffed both clinically and non-clinically to support these young people who are very complex. In fact, I will mention that some of these young people previously were at the Barrett centre. We thought we could not manage them in any other way, but if you provide the right support and the right environment you can do that. I and my colleague here were involved in that. It is possible to do those things. Also, as John said, if they had the resources we could provide a lot more hospital in the home type of services to support people.

Your issue around general practice and access to psychiatry, psychology, social work and OT—those 10, 15 or 20 sessions—is a challenge at the moment. We do not have the workforce. As I said to the Commonwealth government, you can give us 50 sessions, but if I cannot get to see a

GP and there is no psychologist in my area—yes, I might get something online—how is that going to help? It goes back to our issue around workforce distribution, incentivising people for regional areas and doing some things online. It is a combination of those things. I fully appreciate that. I hear every day that people are struggling to see a paediatrician, child psychiatrist or even a GP. Even in a metropolitan area, if you want to see a GP it might take two or three weeks. These are some of the challenges that we currently have. That is not so much just about the sort of investment or the dollars; it is also about workforce and the distribution of that and attraction of that and keeping of that. How do we actually do that? These are some of the things that I think are critical if we are going to address some of the regional issues.

My other point is: when we think about regional areas we have to think about things in a slightly different way, because you are not going to have a critical mass to get a 20-bed acute inpatient unit but it does not mean that you do not have a need for beds. We can use some of the general beds but you also might be able to complement those with other beds. When I went to Trieste, these Head to Health centres, every community health centre had eight beds upstairs in the community. They are not hospital admissions. There is no blue tag that I have been admitted. When things are unravelling for me I can actually go and stay there for a couple of days before things become a crisis and I end up in Rockhampton. We do not have some of those things in our pathways or the milieu of the different service options that we need.

Mr O'ROURKE: In regard to the wellness of individuals and dignity through education, employment and training, is there a role for disability employment service agencies to either increase their scope of works or expand what they currently do?

Mr Frkovic: That is a really important question and a really important area, I think, for people with mental illness but generally our wellness. Yes, sometimes employment can be a hindrance to our mental health—there is no doubt about that—depending on the employment environment, what is happening for you et cetera. But in the main, if you talk to people with lived experience, their families and carers, having a job, having a purpose, having a meaningful role and making a contribution are really critical aspects of my own wellbeing but even of my own recovery from mental illness. I think they are critical aspects.

There is a complexity in the employment space which actually does cause some problems, particularly in that we have the Commonwealth government responsible for employment in the main and then the state government—and we are probably the only state government that does actually play in the employment space—provides employment readiness programs such as Back to Work and Skilling Queenslanders for Work. There is a whole range of those. We provide a lot of those things to help people get the jobs. There are challenges with that. Again I am going to make some gross generalisations here, but, say for example in the Commonwealth program, if you are a person with mental illness who is difficult to place and you are looking for work, your Jobactive—whatever they are called now—or your DES provider, even though they are around disability employment programs, will take you on, but if you are difficult to place—and I am making a gross generalisation so I have to be careful here—they will not spend as much time with you because they need to get paid for placing people who are easier to place. That is the challenge. You get your initial sign-up, you get your 13-week payment and your 26-week payment. If Ivan is still on the books but he has not been placed because he is difficult then I think the ability to get paid as an agency is complex.

The area where I think we have made some major gains with the Queensland government—it has been complemented to some degree by the federal government but particularly the Queensland government—is social enterprises as a gateway into employment. The money that the state has funded—and I think we should be investing more in those—is around giving people an option for a full-time job or a job that suits their needs at the award wage, but that is not driven by profit; it is driven by funding everything like, for example, the Vanguard Laundry in Toowoomba. If you have had a chance to go and look at it, it is phenomenal. It gives people a full-time job and they get paid for what they do. A lot of them have moved on into other work. It actually makes money, pays for itself and, in fact, pays off a loan to be able to provide that service. They are some good examples. The Commonwealth government has just announced it is going to provide individual placement support services particularly for young people through the headspace centres. These are dedicated employment type positions to help young people get into jobs. It is in addition to the DES providers. These are people who do not get paid on an employment outcome; they get paid to help people get into a job. They are the sorts of differences that I think do make an impact.

Dr MacMAHON: You have made a number of recommendations about specific housing supports. I know in your briefing you talked about the intersection between housing and mental health. I wonder if you could talk a bit about the kinds of housing interventions you think we could be making to ensure the housing system we have in Queensland is supportive of people's mental health.

Mr Frkovic: I think again the Queensland government has invested a lot of money around social housing. Part of the challenge is—and I think it was touched on earlier by my colleagues, and we put it in our submission—that we are probably at a phase where we need a dedicated, supported housing plan for Queensland. That is for a range of vulnerable people, whether they have a mental illness, are homeless or are in a domestic violence situation. There is a need to have not just the capital—whether it is public, whether it is community or whether it is private, capital is important—but also the support, which probably is as critical, if not more so, because housing will not work unless for some of these people you provide the support they need to be able to maintain that tenancy but also to help them deal with some of the life issues they are experiencing.

I think we are at a phase—and we put that into our submission—where we need to look at various models across public, community, private et cetera, and they all have merits and can help. I know that Professor Allan Fels has also put in a submission around the Haven model, which is an innovative 14- to 16-unit model that provides particularly for elderly parents who have adult children with chronic schizophrenia or mental illness where you know that at least they have a place to live and they are getting supported. If you look at that model that he has put up, that is just one option. Each of those individuals has accommodation but they also get an NDIS support package so they have the support. They have been even more innovative: 'I have a support package and my two colleagues here share a bit of our support package for supporting us collectively in that facility.'

Some people will argue that, with 14 or 15 people in one facility in Coorparoo, are we just re-establishing Wolston Park? I think we have to get beyond some of those philosophical arguments. We are not building 30,000 or 40,000 units; we are building for people who have a particular need. The NDIS initially talked about no more than four to six people in some sort of joint accommodation. I think they are much more flexible on that now. It is what people want. It is what they need. I think opening up the door to using the NDIS but getting the capital so that people get the support—and then where they need clinical care the public system or the private system can provide that. I think we are on the road, but I think—as you know, we have a housing shortage. If you are in a vulnerable group you are probably lower down the food chain than someone who is up the top, not that there are not too many people who are not vulnerable who are in housing stress at the moment.

CHAIR: Could you clarify these Head to Health centres? From what I have seen online, they are basically an online portal that you go to that takes you somewhere else. Is that what you are talking about here in Queensland or is it more of a physical service?

Mr Frkovic: I am talking more about a physical service that has the online capacity as well, that provides the online support. I will table this for the committee. My colleague Dr Allan and I probably five years ago funded what was called Floresco centres. I might have touched on this before. I was in the non-government sector at the time. Queensland Health commissioned that independent report. The impact on client outcomes, presentations to ED and inpatient services was phenomenal, but, unfortunately, as with a lot of things, as was mentioned before, the funding was only for two years so that particular centre closed down. That model was used to inform the LikeMind centres in New South Wales. It also helped develop the specs for the Head to Health centres.

Queensland has been doing some of this. We have some runs on the board. This is going back to the point of how we scale and how we do this. They are physical locations which integrate public, private and NGO. They do not have an exclusion criteria. People are seen and channelled depending on what they need. Both in Toowoomba and in Ipswich—we had two of them; we only have one now—they also co-located housing, public and community, and employment agencies. When you came in—and this is what consumers said to us—there was one intake, one assessment and one triage, not three. There was one care plan, whether I am seeing my GP, the public mental health system or the NGO. The most difficult one, and John talked about this, was one client information management system. Everybody was able to use one system—apart from Queensland Health or the HHS in both of these locations, and they found a workaround. They would put it into the local system through the centre but then they would feed it back into their own system into Queensland Health.

We have the runs on the board. They are physical. They are public, private, NGO. Have you been to Townsville to see the one there? Have you had to a chance to go? I really would like to see Queensland Health lean more into that one rather than see it as a separate thing out there. I think we have to build the system together. I think we have one now that just operates up in Townsville.

CHAIR: I am trying to get that clear in my mind, because the bilateral agreement talks about Head to Health services. I have seen other sorts of things described online. I am just trying to get a sense of what they are. The ones that participated in this document seemed to be around adult services rather than youth or children's services.

Mr Frkovic: Two kids ones.

CHAIR: They call them something slightly different again.

Mr Frkovic: Head to Health Kids.

CHAIR: Thank you very much for your time today and the many other times you have come, both as a witness and as an observer. We greatly appreciate the work that you do. I think I could say on behalf of the committee, both to the Mental Health Commission and to the representatives from Queensland Health, that we have been greatly impressed by the work across the spectrum in terms of the mental health and alcohol and other drug services. The number of dedicated people out there doing fantastic work, going well above and beyond what they are probably paid to do, is really impressive. Obviously it has been a very difficult couple of years with COVID in the background as well. Thank you very much for your presentation here today. There was a question on notice which we will need a response to by close of business on 12 May.

Proceedings suspended from 1.17 pm to 1.44 pm.

CURTAIN, Mr James, Clinical Director, Lives Lived Well

GILES, Mr Mitchell, Chief Executive Officer, Lives Lived Well

HIDES, Ms Leanne, Professor of Alcohol, Drugs and Mental Health, Lives Lived Well

CHAIR: Welcome. Thank you for coming along this afternoon. Would one of you like to make a brief opening statement? Then we will go to the committee for questions.

Mr Giles: Our vision at Lives Lived Well is to support our clients to live their lives well. Our attitude is that with the right support people can change their lives. We are a solution focused organisation. In terms of clinical services that are relevant to the committee, we have mental health services on the Gold Coast. We have a headspace at Southport and Upper Coomera. We also operate an early psychosis program with Stride down in Southport and we have the Lighthouse program, which is an acute mental health program for young people. We also offer low-intensity mental health services on the Darling Downs through the Darling Downs West Moreton PHN.

We provide drug and alcohol services across a continuum of care, including brief and early intervention and police court diversion. Within the community we have community sites across the length and breadth of Queensland. We offer case management, counselling, groups and ambulatory withdrawal. We have five residential services across Queensland: in Far North Queensland we have Shanty Creek, which is funded by the federal government for Aboriginal and Torres Strait Islander people; in Rockhampton we have Binbi Yadubay, which was recently commissioned by the state government; in Caboolture we offer a service called Wunya, funded by the federal government; in Chambers Flat we have Logan House; and on the Gold Coast we have Mirikai. Our initiatives are around research, so we have a relationship with the University of Queensland which is five years old. We are doing a lot of research across the organisation. We are very focused on outcome measurement and workforce development, and we are also investing in our own infrastructure.

In terms of our challenges, demand management is one of those; another is translating research into practice; another is rising costs. The recent changes to long service leave, for example, this year will cost us $400,000 and changes to super are about $130,000 in the coming year. The last challenge I have listed is recruitment and retention.

CHAIR: Could you step us through your early psychosis intervention service?

Mr Curtain: It is a service that operates with headspace down at the Gold Coast. They have a lot of young people referred in varying states of mental health issues. That service is often in high demand and staff often talk about mental health services generally being in gridlock. Although they are a specialist type service, they often struggle with just assessing whether or not people are suitable for that service. Like all headspaces, the marketing has been particularly good. There is a sense that headspace is the place to go for young people with mental health problems, but often it is not the best so we find that we are in a position where we are not able to help and there aren't others in a position to help, particularly that missing middle that people talk about. It is the people who are in between the low-intensity services or mild to moderate that headspace focuses on, and then there are the more severe and complex services. It has always been a bit of a struggle for us in terms of meeting the need and being okay with long waiting lists and so on.

CHAIR: Is it an early psychosis intervention program?

Mr Curtain: Yes, it is early psychosis intervention. That is obviously an expensive one to run. The federal government has just committed to continuing that service, which is good news for us, but it is expensive. There is a psychiatrist there who needs to be there to run the service, and then some other GPs and nursing staff as well. Our origin requires the clinicians be Ahpra registered or eligible for Ahpra registration, so recruitment is always a challenge. You have demand on one hand and on the other hand a challenge with staffing it. That has been a struggle for a while.

CHAIR: It is not an inpatient service?

Mr Curtain: No, it is all community based, a lot of outreach. I suppose the staff despair a bit and talk to me about how when they started a few years ago they were able to do outreach work and spend some time really building connections and getting to know young people and their families, whereas now they are pretty well always in the office with back-to-back appointments and they do not have the opportunity to spend as much time in the assessment phase. Obviously, case management is more compressed as well. It is a challenge, yes.

Mr MOLHOEK: We spoke on a previous occasion about the research QUT has been doing, and out of that has flowed an approach that is a little bit unique to Lives Lived Well. I would be interested to hear a bit more about that.

Ms Hides: We have been working together for five years now, as Mitchell mentioned. One of the biggest things we have done over that five years is develop a new outcome measures system that is very much at the front end of the service these days. Clients are asked to complete an outcome measure when they first come into contact with the service or come into treatment. Counsellors are asked to give them feedback on that when they do come in, and then they are asked to repeat that measure at one and three months later and receive feedback from the clinicians about how they are going as well as progress charts that show how they are going. That is a central piece of the brief intervention work that we do.

Over the last two years we have developed a new brief intervention that is purpose-built for the drug and alcohol sector. It was co-designed by Lives Lived Well staff and members of my team at UQ. It is evidence informed, so it is based on an evidence based treatment that I developed and tested and that NHMRC funds. That was called QuikFix, and that was for young people in an early intervention space. The first step, if you like, is the grown-up version of QuikFix for people with more severe substance use across the whole age spectrum. We have done an implementation project. We have implemented that across five of the Lives Lived Well services in Brisbane north, and we are evaluating outcomes over 12 months in about 450 clients. We have pretty much finished our six-month follow-ups and we are just doing the 12-month follow-ups now.

That whole strategy with the outcome measures and the brief intervention has had a big impact on the capacity of those services. The enrolment numbers are the same, but having those outcome measures at the front end has freed up staff members' time to focus more on treatment. We have seen no reduction in the number of clients being enrolled into the service, but we have seen double the number of clients receive treatment once they get into the program. We are getting probably about 50 per cent completing the brief intervention. The idea of the brief intervention is that we know nationally that most people who come into drug and alcohol treatment only come in for 1.6 sessions. We thought, 'Rather than spending a whole session doing a large psychosocial assessment, why don't we just get into treatment as quickly as we can?' We feel that combination of factors has increased access to treatment in the sector. Does that make sense?

Mr MOLHOEK: Yes.

Mrs McMAHON: I was wondering if you could take the committee through the facilities you have at Logan House in terms of the service it provides, its capacity, where its catchment and referrals come from, and whether there are similar services nearby.

Mr Curtain: We have had Logan House for a long time. Traditionally it was a therapeutic community. It operated as a residential drug and alcohol rehabilitation facility. It still is that, but on the literature and with Leanne's support and the evidence we have moved to a six-week model. Instead of people coming to stay for six, eight or 12 months, they are now coming in through a really structured clinical program of six weeks. We are seeing some good outcomes through that. Traditionally, capacity was upwards of 30. We have recently revised bed numbers to 25 in keeping with some of the constraints in terms of rising costs and so on, trying to maintain a level of service that is comparable with some of our other facilities.

There are also Logan Family Recovery units there that support families with children for people who are looking to turn their lives around, and that has been really successful. It is one of the few residential facilities where women—usually—can bring children and stay for the same period. Typically, they will stay a bit longer. We allow up to another six weeks for people. There are a lot of referrals through the department of child safety and some nice outcomes through that as well, but generally it is a similarly structured program. We have four units operating there. There is capacity for another unit to open. Again, funding is the constraint for Logan Family Recovery units. We are certainly learning as we go.

As I say, with university support and the outcome measures Leanne was talking about we are really able to assess the impact of what we are doing from that baseline when people come in, then one month, and then typically they have left by three months. We can follow people up and see longitudinally how they have travelled. It has been a good few years as we have started to get a clearer picture.

Mrs McMAHON: With the Logan Family Recovery units, you currently have three facilities available at any one given time?

Mr Curtain: There are four.

Mrs McMAHON: They can stay up to 12 weeks?

Mr Curtain: Yes, up to 12 weeks.

Mrs McMAHON: You talked about the children. What sort of age are you supporting?

Mr Curtain: They are usually younger. We say that we will take children up to 10 or 11. There is a bit of flexibility around that. Typically, they are women with younger children. Once they get to school age it is a bit harder logistically, obviously, getting to and from school and re-enrolling and so on, but usually they are younger children.

Mrs McMAHON: You said that with more funding you would like to open more of them?

Mr Curtain: We have the capacity, for sure, yes. There are six units there all together that we built, so there is room.

Mr MILLAR: I know that you have a Lives Lived Well in Rockhampton. Do you refer out to the Central Highlands and the central west? Is there any capacity?

Mr Curtain: Yes, definitely. We are building connections out there. We obviously have services out in Emerald and Longreach as well. We have been talking with our staff out there just to try and raise awareness, particularly among doctors but medical services generally, as to the availability of Rockhampton. It is certainly a priority area, that whole central, central west, Tablelands region. One of the managers from Rocky was talking to me last week about a trip out to Longreach to visit sites along the way to raise awareness, because for those people it is obviously a lot closer and easier to get to than Brisbane in a lot of cases. Potentially things go wrong between the withdrawal program and getting into rehab, so people will often come to Brisbane to have a safer withdrawal program. In between leaving there and getting into rehab, things do not always go so well. The thinking is that some sort of transport option where we might support people from Longreach, Winton, Barcaldine—somewhere like that—to come across straight into our facility for withdrawal and then transition on the same site to rehab would be a seamless option for rural people.

Mr MILLAR: What do we need to increase your profile out there? What can this committee and the government of the day do to increase that profile?

Mr Curtain: That is a good question. I think nothing beats boots on the ground and those physical visits. That is why Mitchell, the manager, has talked about physically going out there and being present. I suppose often things come back to funding, but GPs are critical in this. They have come to the fore in terms of primary care. It is them having an awareness of the fact that this service is there. It is a high-quality service. It is funded by Queensland Health and it operates very closely with the local HHS, so I think it is reassuring some of those providers about the quality of it. Doing that in person is ideal. We can promote services with brochures and radio ads and things, but nothing beats that in-person connection. We have found that is helpful.

Mr MILLAR: My office is there to help. I have an office in Emerald and an office in Longreach, so if there is any assistance I can give you or whatever, just let us know.

Mr Curtain: Terrific. We will, thank you.

Ms KING: Thank you for the work that you do, which is so badly needed in the community. Could you talk me through the Wunya service at Caboolture? What is the specific focus of the service and how long has it been there? You mentioned that it is federally funded.

Mr Curtain: Yes. It is a 20-bed facility. It is obviously one of our newer ones. It is probably funding benchmarked at a level where we are feeling reasonably comfortable with the ability to operate that service. The federal government has recently committed to continuing that funding for a couple of years, which is great. It has gone particularly well.

I suppose one of the things we reflect on is that it is one site. If you think about Logan House or Mirikai at the Gold Coast, the older centres are a bit more sprawling and spread out. At the facility at Wunya, certainly 20 beds is slightly more manageable. Often we have had up to 42 people in some of those other facilities so Wunya is a manageable size. It is in one place and it is reasonably modern. The fact that its scale is a bit smaller means that we can keep a better eye on things and give people a bit more attention than you might in a bigger facility. I would say it is one of our facilities that we are most confident in, in terms of the running and certainly for me from a distance it is about not having to worry so much, if you like. There is always risk and it is not easy running some of these places, but Wunya is one that runs particularly well for some of those reasons.

Ms KING: When you say that it is all in one place, what is the contrast with some of the other centres? What is not on one site in those?

Mr Curtain: I suppose there are villas, typically. At Logan House you have villas with residents in, the refectory is in one part of the grounds and then the administration block and staff are in another. Similarly, at Mirikai people are spread out. Rocky you could argue is similar, but at Rocky we have visibility of the whole campus from the staff area. We were certainly grateful for the opportunity to be consulted in the design phase. At Wunya you have it all right there. You see people coming and going

and you are checking on people, whereas there is not always line of sight at those other places. I suppose maintenance and upkeep is another big factor. It is a big cost at Mirikai and Logan House, whereas at Wunya you are in one building, there are some gardens and the maintenance is much easier to manage.

Ms KING: How is the service funded from the point of view of the client or user of the service? Do they make a co-contribution?

Mr Curtain: Yes. Typically, we ask for 85 per cent of Centrelink payments to support their admission and treatment program. We would not be able to run the services without that contribution. That typically works well. A lot of people come in with SPER debts and things like that. We can help with that. We help with budgeting obviously and some of the more general lifestyle commitments people have. They can work that debt down while they are there through counselling and engagement with the program, which is helpful too for people.

Dr MacMAHON: Mr Curtain, you mentioned earlier that you do not have the resources to do as much outreach as you would like. In previous sessions we have heard about how important it is to go and meet people where they are. Could you talk a little about the kind of outreach that you do and what kind of resourcing you would need to be able to do that work well?

Mr Curtain: I probably should preface it by talking about the work that Leanne has done and helped us to understand. Traditionally we have felt the need clinically to be present, face to face, with people. Through the work we find that often over the phone is just as effective as face to face. I suppose from some of the more rural areas the learning has been that people are more willing to engage—say, in Mr Millar's territory—if they know that we are present in the same region. We offer low-intensity mental health services through Western Queensland PHN. People were much more willing to engage when they found out that the worker was based in Roma rather than in Brisbane or Sydney. Having said that, ideally an initial face-to-face meeting is great and that goes particularly well.

It is not just a question of resources; it is also demand. If we are taking time out to do outreach and meet with people in the community, it is time away from people we could be seeing or talking to on the phone and offering that service to. It is just a little bit of a caveat that, although the outreach is good and traditionally we have done it, I think with the way the need is presenting these days it is really hard to justify spending a lot of time doing outreach work. We have traditionally done outreach to communities like Cherbourg, say, from Kingaroy and there is no substitute for that. You have to do that. You have to be physically present there and the phone does not work for everyone. However, it is certainly not the ideal necessarily anymore.

Mr O'ROURKE: Lives Lived Well are doing an absolutely wonderful job in Rocky at the new facility. Is it at full capacity? Did you have trouble recruiting staff? Can you talk about some of the day-to-day operational stuff?

Mr Curtain: It has been a great experience getting Rocky off the ground. We have had a really nice opportunity to get prepared. We staffed early and really had a chance to plan that thoroughly so we have a full staff complement, bar a GP. We would love to have a GP there. We have really struggled to recruit a GP. Other than that, it would be at capacity were it not for COVID. We have had up to 30 people in there. There are 32 beds in the rehab unit and eight in the withdrawal unit. If it were not for COVID we would be at that point now. Recently I would say we probably had four to five in the withdrawal unit out of eight and, say, 16 or 20 in the rehab unit. We have just come through the last case on site so we are expecting that will lift now to capacity. The family unit will open on 4 May; it is imminent as well.

As I said, we have a great relationship with the HHS up there and a formal protocol with them, as you probably know. I think with the preparation that we were able to do and the consultation, we had input so have drawn on all of our learnings into the design. That has meant that it is another one, like Wunya, that operates at a level that gives us a bit of comfort. We sleep a bit better knowing that the funding is there, the resources are there and the facility is there. It just works.

Mr O'ROURKE: That is great to hear, thank you.

CHAIR: QNADA has put forward a suggestion to the committee that there needs to be some sort of regulation in the alcohol detoxification and rehabilitation space. Would your organisation have a view in relation to that matter?

Mr Curtain: We would be supportive, I would say. I suppose we see and have a lot of people come to us having experienced some alternative providers, often where there is not necessarily a structured program and certainly not an evidence based program. They might have spent super

money, drawn on their mortgage or whatever and not necessarily made any progress. That is hard to watch when we can see, with a reasonably brief opportunity, people in a lot of cases can, as I say, turn their lives around. I would say we would be broadly supportive of standards, definitely.

CHAIR: To clarify, with your residential services I see on your website that you use the term 'rehabilitation'. Is that from anything? It does not matter whether you have a mental health issue or an alcohol and other drug issue; you manage people in the same space regardless of their presenting condition?

Mr Curtain: We are a drug and alcohol treatment service, so typically people should always have a drug or alcohol issue. We are finding more and more that mental health is a major factor and the acuity we are seeing in those settings has really lifted, which meant increasing capability of our staff in terms of comorbidity. It is particularly challenging when mental health services are also at capacity. As I say, we might have shared care in the past or you might have had someone with a primary service being mental health and we would do some ancillary work. We are finding a lot of it comes to us these days so we have to navigate some of those really highly complex people.

CHAIR: Do people need to have gone through a detoxification process before they come into your residential service or are you able to provide that as part of what you do?

Mr Curtain: We can provide it in places where we have withdrawal units. We have one down in Wollongong, and obviously Rockhampton has a withdrawal unit attached. We have some community withdrawal programs these days. Ideally, if someone has high-level alcohol use particularly we would like to see them go through withdrawal first. We get a lot of people coming who have not necessarily withdrawn, even though they might have told us that they have, so we have to manage that. Fortunately we have RNs at every site so we are at least able to have some medical personnel on hand. However, ideally they probably would have had that withdrawal process before they come to us. We have to monitor people very closely in those first few days.

CHAIR: My next question really is around the planning of services. I am not sure if you heard our earlier sessions but the federal Productivity Commission has talked about the need for planning at a more regional level. Depending on the region, are you folks involved in the planning of alcohol and other drug services on a regional basis or do you do what you do and everybody else does what they do?

Mr Curtain: Things are busy, I suppose. I think there are opportunities at sector level and at regional level to be involved. We do to the extent that we can. Certainly our local managers are very active in the local regions, wherever they might be. Typically they are divided by PHN area. We try to get involved there where we can. We are certainly happy to be involved, but it is probably not always that we are able to.

CHAIR: Thank you for your time this afternoon. We have greatly appreciated you coming along.

BYRNE, Mr Matthew, Accredited Exercise Physiologist, Exercise & Sports Science Australia

HOBSON-POWELL, Ms Anita, Chief Executive Officer, Exercise & Sports Science Australia

CHAIR: I now welcome representatives from Exercise & Sports Science Australia. Thank you for your time today. Would you like to start by giving us a brief opening statement and then we will go to the committee for questions?

Ms Hobson-Powell: First of all, I would like to acknowledge the traditional custodians of the lands, seas and waters throughout Australia and particularly of the lands from which we are speaking today, the Turrbal people. I pay our respects to their elders past, present and future. I also acknowledge any of the Aboriginal and Torres Strait Islander people who may be involved with this inquiry or listening to today's proceedings.

I am the CEO of Exercise & Sports Science Australia and I have been there since 2006. I am also the chair of the National Alliance of Self Regulating Health Professions and the deputy chair of Allied Health Professions Australia. I am joined by Matthew, who is our exercise physiologist and runs multidisciplinary physiology clinics that include people with disabilities, older people and people with chronic conditions and mental health. ESSA is a peak body for exercise and sports science professionals, with over 10,000 members nationally. Our exercise physiologists apply broad skills across the healthcare, aged-care and disability sectors. They are recognised as an allied health professional and have a university degree, minimum of four years.

Given the spread of the COVID variant and the recent floods in the Queensland community, we would like to express our genuine concern about the increase in mental health impacts facing our community and the challenges in accessing allied health services across the public and private sectors. Whilst COVID cases continue to put the Queensland health system under pressure, ESSA is concerned about the mental health of those with long COVID and is keen to see multidisciplinary care models established in Queensland, such as the model at the Royal Melbourne Hospital's post-COVID clinic, which helps patients with their anxiety and depression.

Furthermore, we would like to highlight the impact of living with psychosocial disabilities, the ineligibility to access NDIS services and the limited access to other mental health services. There is an enormous amount of evidence to show that the focus on physical health has a significant impact on mental health and that treatment of physical health can impact patients during their mental health treatments. The engagement of exercise professionals such as exercise physiologists and exercise scientists offers evidence based solutions in addressing the challenges in preventing and managing mental health conditions and improving the health system's sustainability. Of note are the consistent messages from other government inquiries into mental health, such as the Productivity Commission's mental health inquiry and the Royal Commission into Victoria's Mental Health System, which acknowledge the need to include exercise and dietary interventions as a component of care.

There are over 6,000 exercise physiologists in Queensland with the capacity to support Queenslanders in living healthy lifestyles. Unfortunately, only nine are employed in the healthcare system in Queensland. ESSA is advocating for exercise physiologists to be engaged as part of the multidisciplinary team in every hospital and health service to ensure there is holistic treatment for people with mental health conditions to look after their physical wellbeing as well as their social wellbeing.

The Royal Commission into Victoria's Mental Health System noted that community-led interventions involved in social connections such as group exercises demonstrated a most positive impact on one's mental health and wellbeing. Group exercise classes show a reduction in healthcare costs. Treatment of physical health with support of people with mental health conditions should be part of standardised care and part of a systematic referral system, especially to exercise physiologists. In the private sector, exercise services are expensive and out of reach for most people with mental health conditions. The only compensation available to them are the Medicare chronic disease items of up to five sessions. There is no access to exercise treatments through the Medicare mental health plans.

Finally, the transition of people with mental health conditions from the public to the private sector is disjointed. Access to the Viewer for exercise physiologists would improve patient outcomes and the delivery of services to this population. I look forward to expanding upon any of my comments or our submission.

CHAIR: Thank you. From a clinical perspective, I was just trying to get an understanding of what exercise physiologists potentially or actually do in relation to a patient in a mental health inpatient facility or a rehabilitation program.

Ms Hobson-Powell: There is a belief that exercise does not help treat or cure mental health conditions. That may be the case, but it also helps manage the conditions. In particular, there are a lot of physical side effects that happen with mental health. You can see that often there are side effects with medications. You will see weight gain with some of the medications. That certainly helps with that. Exercise helps obviously with hormones, increasing the joy that you have when you are participating in exercise, with that social connection that happens. A lot of these populations have quite significant cardiovascular diseases attached, so I guess we are working on a lot of other things that come with the mental health.

Mr Byrne: I cannot speak from an inpatient perspective but from a private clinic perspective. There is plenty of research around exercise assisting with mental health. We try to help people manage their day-to-day. They will come in and have goals. Our goal basically is to assist them through exercise to achieve what they want to achieve. Depending on what mental health condition they present with, that presents different challenges and different sorts of clinical presentations. It is our job basically to work around that and get them to start moving and moving towards their goals. That is sort of what we do.

CHAIR: I heard the federal Mental Health Commissioner give a talk seven or eight years ago. I was there with an interest in stroke of all things, but they actually said that the sorts of things we do around stroke and diabetes and preventive measures have extremely positive benefits around mental health issues. He certainly cited quite a range of research in relation to that. There is obviously something there. You said there are only eight exercise physiologists?

Ms Hobson-Powell: Nine exercise physiologists employed within the hospital and health systems.

CHAIR: In a mental health context or in a non-mental health context?

Ms Hobson-Powell: One is employed in a mental health unit and the others are more in the community based settings.

CHAIR: We have had evidence proffered to the committee through other submissions and witnesses that people with mental illnesses have a much reduced life expectancy in Australia. Is that something that your organisation is able to back up with evidence?

Ms Hobson-Powell: Yes. There was a *Lancet* journal published about three years ago with a whole series of articles around mental health and physical activity. It is about 25 years reduced life expectancy. A lot of that, though, is because of the cardiovascular issues that present with people with mental health conditions. Because they are not out exercising or doing physical activity, it is putting a strain on their cardiovascular systems.

Mr Byrne: I can give a clinical example. The medication that schizophrenics require will often cause them to be at risk of diabetes later in life. Say they are a younger schizophrenic, it is about trying to prevent risk of diabetes later in life. If they get those comorbidities, there are reduced life expectancy knock-on effects.

Mr MOLHOEK: I am just having a look at your recommendations. I do not think there is much argument that exercise will help people, but exercise is a little bit like new year's resolutions: a lot of people make commitments like, 'I'm going to exercise more, I'm going to get healthier and I'm going to eat less.' Do you have any evidence or data around the success rate of actually getting people with mental health issues to engage in greater levels of activity and the outcomes of that?

Ms Hobson-Powell: There is plenty of research across various mental health conditions on how they respond. I guess it comes down to what you are looking for as the evidence to show that exercise is working.

Mr MOLHOEK: It is probably more about the engagement.

Ms Hobson-Powell: Do they maintain it?

Mr MOLHOEK: How many people actually take up the opportunity to get involved?

Ms Hobson-Powell: Depending on what stage they are in in their mental health cycle, there will be periods when getting them out of bed and out of the house is a struggle. What exercise does, particularly when they are involved in group exercise, is give them a commitment and accountability that they need to turn up. In New South Wales—they had it running through one of their headspace programs—they would come in for their psychology appointments and then they would have an

exercise session immediately afterwards. They were already getting there and were committed; it was keeping them there and engaged. For a lot of them, it takes about eight weeks to start to see the benefits and then they are motivated to continue.

Mr Byrne: I do not have hard data. I am happy to see if I can provide any research paper at a later date for the actual numbers for take-up and those sorts of things. From the perspective of a clinician, the hardest part is often just getting them there. Once they are there, you can start and show them the benefits of exercise. Our job is a lot about lifestyle change. The first session may not even be any exercise. You are just talking it through and working with them. From there, we start with something small and build up that self-efficacy and then you see some benefits from there. They feel better in themselves and it has that knock-on effect.

It is hard. Mental health clients are incredibly difficult at times, because you do not know how they will present each session. You have some really good days and it feels like you are on top of the world and then at your next session it is like you never existed and everything that you just did went out the window. It is hard to give you a hard number, but we have found that if you can get them started and you can get them there then it is our job to just keep them moving.

Mr O'ROURKE: Your recommendation No. 8 was around some of the concerns with the NDIA and NDIS. Can you talk to that for me, please?

Ms Hobson-Powell: Matt will give a perfect example. The main thing we and a few other allied health professionals are facing as clinicians, as experts in what the client needs, in providing recommendations to people who make the decisions about where funding is going, is that often they are choosing cheaper options. In our case, they will be using a carer to provide exercise advice. As Matt presented, you do not know how someone will turn up each day. Will the carer know exactly what they should be doing with their exercise or has their medication changed? That will impact how we are going to deliver services. A lot of our recommendations as to what is clinically needed are being ignored.

Mr Byrne: From a private perspective, engaging with the NDIS has been a wonderful opportunity for people with disability, but it can be incredibly frustrating at times. On our end, each time a participant comes in we have to, at the end of their plan, provide a review and recommendation for treatment moving forward. We will do some testing, show how far they have come and then provide research to back up why we are recommending X amount of funding. The planners receiving these may not have a health background and their health literacy may not be there. We will write in as layman terms as possible, but it may not be understood and the benefits are not as clear to them as to how that can work in. I understand that it is an insurance scheme and that we have to try and mitigate risk for the future down the road, and it feels like exercise is perfectly placed to help mitigate risk for the future, but that is not always being conveyed or understood with the plan.

For example, I had a lady with schizophrenia. We made some really good progress. We sent through the review, we asked for X amount of funding and we got about half of that. It came back that, basically, the exercise was not assisting with schizophrenia. This lady was overweight and at risk of other comorbidities. This is a lady who sometimes does not get out of bed. Just getting her to the clinic was a really big win. She loves Taylor Swift and Simple Plan. To get her in, we literally just play those bands, she comes in and she does her exercise. They refused funding because it did not affect schizophrenia. She had all these other comorbidities which we were addressing which could then help to improve her mental health. Fortunately it was overturned in the review, but these are the sorts of tightenings we are facing.

To address Anita's point, we are getting asked if carers can do the exercise at home. What if they hurt themselves at home? I have a prescribed program but someone else has delivered it. Who is at fault if someone gets injured? There are a lot of potential things to go wrong. We spend four years at university to deliver this. It is not something you can just palm off to someone else.

CHAIR: The NDIS is often focused on the one-service-for-one-person type model, but you talked about the benefits of group approaches to fitness. Do any of your members work in with community organisations and provide more of a group type approach to exercise physiology?

Ms Hobson-Powell: There are a few different models. Some will run them as part of their own clinic. They will come in and often they will start with one-on-one just to get stable, to understand the condition and to understand what is going to be required of them, and they will transition them into groups. For some people, it is actually much better for them to be in that social setting.

A lot of the work that we do is also setting them up for life, so they do not have a complete reliance on the exercise physiologist. Matt will write a program which will require them to do exercise that is not just with them. It could be that they have the local facility down the road and they can go

and join them, or there could be a local walking group. They will give them lots of options. We are trying to change their behaviours in their day-to-day lives. It is looking at what is in their community that they can engage with and what the person is actually interested in doing as well.

CHAIR: Have any of the sporting and recreational organisations made any progress in terms of supporting people with mental health issues to engage in their sporting activities? I know there has been a lot of good work done particularly in the area of people with intellectual disabilities but I wonder if any of that has translated across.

Ms Hobson-Powell: Probably not so much. The major problem has probably been that no-one has really owned this space. Sport Australia released some grants at the end of last year, and they were the first they did which were focusing on mental health. We have received some funding to do some rural and remote activities around mental health, but it has not been the priority of sporting organisations in the past.

In the fitness space, we are seeing a growing push by the fitness industry to look more at that prevention and marketing to show the benefits of exercise. COVID has definitely heightened everyone's awareness about physical activity and mental and emotional wellbeing, because that was one of the reasons you were allowed to leave the house. A lot of the fitness industry has picked up on marketing that space. We are doing some work in the fitness space to better connect fitness and health, because there is a point where you need to refer them on to a clinician who has a better understanding of their mental health status. Having mild depression is not a problem for them to go into the fitness space, but if they have schizophrenia they need to be seeing an allied health professional, so how do you create those partnerships with health and fitness?

CHAIR: Are there examples from other jurisdictions in Australia or internationally where exercise physiologists have been well integrated into a multidisciplinary team approach to care for people with mental health issues?

Ms Hobson-Powell: There has been more with headspace in New South Wales. Their Bondi clinic has been probably the leader, and that was an example I gave before of when you come into headspace and you see a team of people while you are there, so you are captured. That is working well. They are seeing the psychologist, the dietician and the exercise physiologist. Belgravia Leisure in Victoria are more of a community fitness centre, but they are integrating with health. They have a connection with the GP clinics that are close by. They will see the GP clinic, they will come in and see the exercise physiologist and then they have access to the leisure facility as well. I guess it is expected within the DVA circles that if you have a client presenting with PTSD they are part of a mental health community who are engaged in servicing them.

CHAIR: We have talked a lot about mental health. What about the area of alcohol and other drugs? Is that also an area that exercise physiologists can play a role in? Is that something you are already doing?

Ms Hobson-Powell: It is growing. It probably has not been seen as an area where exercise physiologists can be of benefit, but we are seeing some facilities actually engaging. It is treating it as an addiction. Again, it is very similar. A lot of these people present with mental health conditions. There is a facility in Toowoomba—and I am trying to think of its name—which only has 20 beds and it is drug and alcohol. Part of it is that they do exercise every day, and they have an exercise physiologist who is brought in to work with them and set up the program and then they are also taking them out into the community to exercise. That is definitely a drug and alcohol facility that is doing that work.

Mrs McMAHON: Your submission goes into some detail about the role within the acute setting and in that multidisciplinary setting. A lot of what this committee has heard does look at that missing middle—that is, the people who need something more than a GP but are not at that hospital level. I note you had a couple of recommendations about MBS in terms of referral pathways. What sort of person would a GP consider referring to an exercise physiologist, as opposed to just saying, 'You need to get out and do some more exercise' or that they need to be more active because of their BMI et cetera. Where does an exercise physiologist fit into that area between seeing a GP and getting some medication but not needing hospitalisation or acute treatment?

Ms Hobson-Powell: It does rely on the GP having some understanding of the client and whether they are ready for behaviour change. If the GP said to a person, 'You need to go and do some exercise,' and they believe they will do it and can do it themselves, then they do not need help. It is about understanding what behaviour change looks like and how they do the steps, whether they have underlying conditions, what medications they are on—and then they should definitely be referred. For some of these people, they may need just three or four sessions and that will set them up. Others will need ongoing.

Mr Byrne: From a clinical perspective, it all depends on the GP's knowledge. There was research—and I am not sure if it was ESSA led—saying that if GPs exercise themselves they were X percentage more likely to use exercise as a treatment model. A big part for us is going out to general practices and educating them on what we offer and how we can fit in.

I will use diabetes as an example. Diabetes has a separate MBS scheme where you can get group classes. That is through an exercise physiologist, a diabetes educator or a dietician. They have one one-on-one consult and then they are eligible for up to eight group classes that have a Medicare rebate on them. We would go out to these GP centres and they would not know that they exist, and these GP centres have been there for 15 years. If you take care of a diabetes patient's blood sugar, if they are not having highs or lows, if they are not having falls and then presenting to ED because they have fallen over having a hypo, you reduce that risk. You provide that education in those group classes about how to manage that.

For mental health, there is a mental health scheme but we are not a part of it. The GP might refer through the care plan and it will often be anxiety or depression and it is often with a comorbidity. We are starting to see more and more GPs refer just for anxiety or depression and then getting in early to help use that to give them the tools to manage. We do a lot of health behaviour change and, like Anita said, looking at where they are on that behaviour change model. That is where we fit. It is hard to say nicely where we fit because it all depends on how they present to the GP.

Mrs McMAHON: Your recommendation 16 is around the Exercise is Medicine module, and that is part of training GPs as to the benefits and where that fits in.

Ms Hobson-Powell: We did some research a couple of years ago and found that basically through a medical degree you will get either four or up to six hours of education around exercise, so the GPs are not getting much at all. We developed a training module called Exercise is Medicine. It is quite generic at the moment around the benefits of exercise. We pick a few conditions and the outcomes you can see, and we talk about the referral pathways in place. What we are looking to do now are some very specific ones around particular conditions and the benefits of exercise—what outcomes you should start to see in your clients, how you can be monitoring to see there are improvements happening and, again, what the referral pathways are, particularly for those conditions.

Mrs McMAHON: So when a client presents to a GP and the GP starts looking at medicating for anxiety or possibly depression, there would be a training module that would also say, 'Whilst you're handing out your prescriptions, consider referring your client on to'—

Ms Hobson-Powell: It is much easier for them to write a prescription than to actually go through this. The work that we do through Exercise is Medicine is asking doctors to ask their patients two questions. The first is, 'Are you exercising?' If the answer is yes, then the doctor would ask them, 'How much are you exercising?' What we found then was that the GPs were not too sure what to do when they got the answers back: 'If they're not exercising, what do I do?' We were trying to give them some advice on just basic information they can give their patients but then also to understand that, if they get these things presented, they need to refer to us, to the fitness industry or to a physio. It is understanding what the client is and what stage they are at.

Mr Byrne: I presented one of those to our GP centre upstairs and they found it really useful. There are about 15 GPs upstairs and we were able to sit down with them during their lunch time. We did it over three different lunch times and presented 20-minute slots. It was a really good chance for them to basically get a rehash on what exercise is and for them to realise that there are other options throughout different conditions on where exercise can fit and how they can prescribe that. We did see an uptake in referrals to us and we were then able to assist their patients.

Dr MacMAHON: I was hoping you could elaborate on the concept of social prescribing that you have mentioned as one of your recommendations. Alongside recommendations to go to a physio, what other things might be included in social prescribing? How do you think that might be funded?

Ms Hobson-Powell: I cannot answer the last one because I think that is a live discussion on how that will be funded. We do not think exercise is owned by anyone. The physical activity levels in Australia are very low, even though we are seen to be a sporting nation. It is basically trying to get everyone to take some accountability over getting people active. They may present to their dietician and they may look, as we mentioned before, around what activities are out there in the community that the person could be involved in. A lot of these social prescribing activities end up being these group activities—for example, the Heart Foundation walking or parkrun. How do we get them involved? Sometimes it is not the doctor or a health professional telling you that you need to be going out and exercising; it is other people in the community seeing the value. COVID has had small blessings with the constant message of the importance of exercise for your physical activity and also

your mental and emotional wellbeing. It is getting everyone to own it and think about how we get everyone active because we will see benefits, but it comes down to the fact that we have no idea how this will be funded.

Ms KING: I want to ask your thoughts on the NDIS model and the emphasis on it as an entire funding system of disability. Does the idea that people are at risk of losing their package if they recover or improve create complications for exercise physiology being prescribed or part of, say, an NDIS package in the way that you have described?

Ms Hobson-Powell: I would say generally that something is needed so it is better than nothing. I think it is being complicated around a few areas, and one is who can access the scheme—not only the individuals but also the providers. The rigour that the people have to go through to actually become an NDIS provider is very cost prohibitive. Often you will see small businesses not going down the official registration process because it will send them bankrupt.

The concept of patients having a say in what their treatment is has become really important. As highlighted before, the biggest problem in the system is that they get a packet of money and often the people who are making the decisions do not have the clinical knowledge to understand what the best outcomes are. A lot of the time it is trying to get second-rate services, if I can say that, to these people who actually need higher levels of care, but I appreciate there are also limited funds that are available. There are pros and cons to it.

CHAIR: I would like to thank you for your presentation today. It has been useful and interesting. I have to admit that I always thought exercise physiologists were a type of physiotherapist but I have been re-educated. If nothing else, that is what your submission has achieved—but I am sure it has achieved much more than that.

ASHLEY, Mr Simon, Chief Executive Officer, Atune Health Centres (via videoconference)

CHAIR: Welcome. Thank you for making yourself available today. Would you like to make a brief opening statement and then the committee will ask you some questions?

Mr Ashley: Thank you for this opportunity. I count it as a great privilege. As an introduction, I have been on the journey of building an integrated health centre for about 25 years. I nearly died when I was 19. Through that experience, I recognised that there might be a few areas that could be improved in the health system, so it has been my lifelong goal to build or establish centres like this and potentially help the health system recognise and look at change. For me to have the opportunity to speak to you today is something that I have been working towards for many years, to be honest. I count it as a great privilege.

Atune is a centre that I started about 14 years ago. I started it in the front room of my house and we have grown very quickly. We now have about 120 staff who work for us in the building and the business. The premise of the business is that it is integrated. I do not lease space. Everybody who works in the building or for Atune works for Atune—whether it be specialists, doctors or allied health. We have 18 different health disciplines that all work together. The purpose of that is to actually coordinate the care. It has gone extremely well. We have grown very quickly. Both the practitioners and the community absolutely love that type of care. About 18 months ago we built our first purpose-built centre, which is a building of about 3,500 square metres which houses our integrated centre. That is a summary for you. It is a private entity. We do have a lot of things around that with public health and that sort of thing.

CHAIR: Thank you. Are mental health services offered as part of your integrated health service?

Mr Ashley: Absolutely. We have a psychiatrist and 10 psychologists, as well as other bits and pieces around that. We have several groups and then there are a lot of integrated services that blend into that. For example, we have an integrated oncology unit which basically supports clients with oncology, but of course mental health is a significant component to that that we are able to service as an integrated team.

CHAIR: You may have heard the end of the exercise physiology presentation we just had. We have heard a lot about the segregation of mental health and physical health. Has it been the experience of your organisation that you are better able to provide holistic care across people's physical and mental health needs?

Mr Ashley: Very much so. I have some statistics that I am happy to share. When it comes to mental health, the physical health component is almost doubled in a lot of people—with heart, cardiovascular, other things like that—just because of their mental state. Having the teams of people working together is a lot more effective, and therefore it is much more cost-effective, I believe, in the long run when it comes to a client's outcomes and actually getting compliance. If you are working in isolation, it is a lot harder to get compliance around exercise, smoking or diet; however, if you have a team of people working with these clients, there is a greater ability to get the clients on that journey.

We also have a lot of support groups that support them. That peer-to-peer support from people who are in the same boat helps them spur one another on. We have a few of those that have been running that have been very successful. It helps both. What we are finding is that when you have someone with mental health issues it is very hard to get them to do exercise if you are working in isolation, and vice versa. With psychological intervention, if we cannot get them exercising they are not going to recover as quickly. Getting them both working together has a real powerful synergy that we are finding is beneficial for our clients. We are not working with the acutely ill. We are working with those you are talking about, which is those in between, those middle ones who are not in hospital but are out in the community who still need to progress their therapy.

CHAIR: Do you also have people with alcohol and other drug addiction issues who utilise your service?

Mr Ashley: Absolutely. There are always going to be people like that who require that. We have a smoking cessation class that we are about to start. Now that COVID is starting to settle down we can have some of these groups happening again. We are going to be doing that. All of those things work in together to support the client on their journey. It helps them. Sometimes people only want to have one thing; sometimes people recognise that there are multiple comorbidities they have that they need to address. To have that team actually supports them.

CHAIR: How is all of this funded?

Mr Ashley: That is a very good question. There are quite a few barriers to the integrated service. For example, we have joint consults with our GPs, but one of the problems with a joint consult is that the doctor will get paid through Medicare but our allied health will tend to give up their time or the GP will give them some of their billings to help pay for that session. Those joint consults are invaluable when it comes to the client's progression. What we have done is we have a levy here at Atune. Because it is an integrated centre, people want that type of service. We recognise that it is a high-level type of service, so every client is charged a $1 or $2 levy which goes into a bucket to help us fund some of the services and things that we have. No-one has ever questioned that at all. Our staff are very happy with that because they want to be able to provide the integrated service, but there is no other way of funding it at this point.

Dr MacMAHON: I have a question about the value of having all of these services in the one place and the intersections that you might see between different issues that people might be presenting with. Why is that hub model valuable?

Mr Ashley: There are hub models and there are hub models, to be honest. I have seen a lot of the superclinics around and they are not a hub model; they are people located in a building but they are not actually working together. If you truly want to have a hub model work, it needs to be developed from the ground up. It needs to have a business approach to it. That is one thing I would say.

In terms of the value, we have integrated oncology, we have integrated support, we have integrated sleep. Sleep is a massive problem for people with mental health. As we have collaborated, we have recognised that there are these different areas that require greater attention, if you like—such as, who looks at lifestyle interventions for sleep? We have recognised that sleep is a very significant aspect to a lot of people's health problems, and if we can address their breathing issues, their nutrition, their coffee and their habits and actually help them get onto a better level, it is amazing what it does to their mental health and how it can change that. Out of the collaboration has come some very specialised areas that have been great services for our community.

Dr MacMAHON: Do you know the number of people who come in for physical issues who are then referred through to mental health services? For example, someone comes in for dental care or something else and then there is a recognition that they have mental health issues and they are referred to other parts of the service.

Mr Ashley: I cannot give you specifics. We just changed our whole system to be able to provide that type of information long term. What I can provide is that of the 50,000 clients that our business services about half are accessing the integrated services. I would say that there is quite a large portion. There is a comfort in coming to see a psychologist and then seeing someone else just down the hallway. The way we do the handovers is that the psychologist will go and see the dietician and they will organise a five-minute handover. That is a powerful way of getting people to that next step. We are not trying to process people through a system; that is not what it is about. It is about giving them the care that they need. We are finding it very powerful.

I am sorry that I cannot give you that statistic because we have not been able to filter that through. We are starting to push into research in these next few years. We recognise that that is where we need to take things, but we have not set ourselves up at this point because we have really tried to provide the services rather than do the research. I can say that there would be a lot who have benefited.

CHAIR: I have had some involvement in some specialist health services here that cater to people who are refugees or from a migrant background. These organisations have started out in the health space but have found themselves having to provide a broader range of services, particularly around legal support and social support. Is that something that your organisation has delved into, or do you stay very much focused on the health needs of people?

Mr Ashley: We certainly have recognised the need for a lot of that. We are already doing things that are quite unique and different anyway, so instead of starting to push into other spaces that are not what we are supposed to be doing as a business—because we are really about health—we will outsource that. We have good connections with people who can do that. We feel that we have to stay true to our purpose, which is providing great health care. We do not want to blend the two because that gets too messy.

CHAIR: How do people get referred through to your service? Where do they come from? Do they come from all over?

Mr Ashley: They do. We are located in Newcastle and we have people at the moment coming from Sydney, Tamworth and right up to Port Stephens to access our service. It is by referral. People can just ring up and book themselves in if they have heard about us. There are multiple avenues for

people to come to us. We have a lot of specialists refer to some of our programs and our clinicians. Others just come along because they have heard about us. It varies. We do not have one particular method.

CHAIR: Do you refer people on if there are limitations in your service?

Mr Ashley: Absolutely. We very much recognise what our area of expertise is. If you are going to be truly integrated, you have to also recognise what your limit is. I think that is one of the big problems with some of the health areas, to be honest. People think they can treat everything or at least delve into areas where they should not be. We have a very strong referral system and have a lot of strong connections with different organisations that we know do something better. To be honest, that is what is going to be better for the client. If they trust us and we can give them a trusted source, they are more than willing to follow that.

CHAIR: You mentioned on a few occasions your oncology services. Are you providing chemotherapy?

Mr Ashley: No. We work with the oncologists. We are blending that type of treatment with, if you like, the complementary and allied health services. We recognise that is our area. The oncologist works where he works, but they know the system that we have which covers all of the other things, like exercise, supplementation, mental health, acupuncture. We cover all of those for them so they know they can refer their clients to us for that.

CHAIR: Would that include psychological support and emotional support if that is what is required?

Mr Ashley: Yes, absolutely.

CHAIR: That is interesting. How, if at all, well integrated do you feel your service is with the local public health system in terms of both the physical and the mental health side of things?

Mr Ashley: That is a good question. I would love to say that it is. I can see an incredible gap that we can help that system with. However, I think we are probably paving a way a little and people are trying to understand what it is that we are trying to achieve. I would say that the connection is not as great as I would like it to be. Certainly there is appreciation of what we are doing, but I do not think people recognise the scope and the ability that we can have. We are seeing that change but it is usually individual rather than organisational.

CHAIR: You said you were in Newcastle. I am not particularly familiar with that part of the world. Are you in an area where there is a lack of GP services or other types of primary health services? Is that why you are there or is it just that you started out there because that is where you live?

Mr Ashley: I live here. Where we positioned ourselves is central to the whole Hunter. It is really a regional hub we have created and that was purposeful. I live very close to the John Hunter Hospital, which is probably the biggest hospital in the northern part of New South Wales. I started the business here because this is where I live and it is where I work from. I certainly have plans to take this type of concept across Australia because I believe it has great validity for our communities.

CHAIR: Do you have a particular health background or profession yourself, Mr Ashley?

Mr Ashley: I am an osteopath by trade. I worked as an osteopath for about six years. I was always wanting to run medical centres like this.

CHAIR: As there are no other questions from the committee, I thank you for taking the time today. I am pleased we reached out to you. Thank you very much for your time today.

Mr Ashley: Thank you so much. All the best with it.

BOYD, Mr Darius, Brisbane Broncos Ambassador, Broncos Wellbeing and Resilience Program Facilitator, Broncos Resilience Training Program (via videoconference)

JURD, Miss Katherine, Broncos Community Programs Manager, Broncos Resilience Training Program (via videoconference)

CHAIR: I now welcome representatives from the Broncos Resilience Training Program. It is a shame Jonty Bush, the member for Cooper, is not here, although she was here this morning. Jonty introduced you to me at the community event she held in her electorate, which was great. Would you like to make a brief opening statement about your program and then we can open up for some questions?

Mr Boyd: Thanks for having us; we really appreciate it. We run our mental health and wellbeing workshops through 53 schools, normally with Indigenous children from those schools—Aboriginal and Torres Strait Islander kids. Some of the things we talk about are mental health and mental illness; protective factors, which we think are really important; as well as some risk factors that, as young people, you might see. With those protective factors, we talk about strategies and tools that we can give them to implement at an early age. They can take those away and work on them away from school, at home, with family, with friends. They are things that do not take a lot of time out of your day but they can really help you get back on track, build some resilience and make sure that when those challenges and different events—the roller-coaster of life—come about, they are more equipped to deal with some of the challenges they may face.

The need we found in that space is around increased anxiety around bullying, COVID and different challenges with social media. There have been delays in coming back to school; there is trauma. There are so many different challenges that young people face today. We have a bit of a proactive approach and a preventive approach. It is a salutogenic approach. It is the positive factors, tools, tips and strategies and support networks.

As the Broncos, we have a really good platform with the brand and the Bronco crest on our shirts. When we go into the schools, I think the kids feel a sense of belonging and a sense of trust and support instantly from having seen some of the ambassadors that we use on TV. They feel a sense of trust and support automatically, and hopefully that opens up conversations so that when we do go into schools the conversations are a lot easier and maybe they will take some of the tools and tips that we give them on board.

We use a gratitude journal. We really enjoy giving a gratitude journal to each student. It is something tangible that they can take away. They can take it home and practise. It does not take much time out of your day to write down some things that you are grateful for from your day. You can write down a challenging moment or event that has happened in life. I think that is a really positive strategy and we have had some good reports back on what it does, how it has been received and how it has helped some of the students we have spoken to and come across over the past few years that we have been doing this.

The last part is about why we are in such a unique position. As the Broncos, we have a great opportunity to go across a wide range of schools throughout South-East Queensland to do what we do. There has been a lot of positive feedback. We do not get into a lot of schools as much as we would like to. We would probably like to grow the program to be bigger and to venture out to more schools and have more ambassadors to facilitate the workshops. At the moment it is probably a reactive approach from a lot of schools that call us, wanting us to go out and speak to different grades or the whole school at assemblies or to different classes—boys or girls; it does not really matter.

With the position we are in we have a great space to be able to do what we do; however, we would like to be able to do more of it. We want to have a proactive approach and, I suppose, work with the schools and alongside the curriculum, not be something that is outside and taking more of a reactive approach. We want to be more proactive. I think that is basically all I had to say from our point of view of what we do, why we do it and why it is important to us.

CHAIR: Thank you for that. The Broncos is a private business, effectively, and could choose to deploy its resources in any way it wants. Like most businesses, they have marketing people. Obviously being a sporting business they have people focused on training and development and all of those sorts of things. Do you know why the organisation has chosen to put resources into a program that is effectively about improving the mental health of young people?

Mr Boyd: That is a good question. Kath might be able to answer it better than I can. I think for us, obviously being known as a Rugby League and a sporting organisation, we were known to be a powerful sporting organisation with what we do on the football field. As our performances on the field

have said over the past few years, they have not been as successful as they may have been in the past. I think what sets the brand apart from others is that we pride ourselves on what we do away from the Rugby League field in helping Queenslanders. We are a community based team. We have a lot of support, with probably one of the highest fan bases in the NRL as a whole, across the code. I think that says volumes, not only of what we have done as a club in its previous success on the field but also, more importantly, some of the programs that we want to run and continue to run off the field, which I think says volumes about the organisation and the people inside it.

Miss Jurd: For us as the Broncos, the community and the department, our why is pretty simple: it is because we should. As Darius was just saying, we have a huge fan base, we have a great following and we have a great position to be able to engage with families and communities and influence them in a positive way. For us, that is our why: we should do it because we can.

CHAIR: In terms of the actual program that you roll out, is it something you have developed or is it something you have borrowed from somewhere else? Is it evidence based?

Mr Boyd: It is something that I suppose we have kind of manufactured with evidence and also a bit of lived experience. That is something I have been passionate about for a long period of time. Originally it is something that I started myself. After checking into a mental health facility myself, personally I have learned a lot of strategies and tips from lived experience. In the last few years we have developed it more into a program of evidence based work. I think it is Dr Seligman who has the PERMA model. We focus on the PERMA model, which is something that I think is going to be important. It is all about different ways to have meaning and purpose in life. Accomplishments, health, positive interactions, engagement and relationships are all the pillars of the PERMA model. To simplify it in particular for schoolkids we talk about gratitude, empathy, a support network, healthy relationships, milestones and exercise. That is a simpler approach for young people so they can understand what those things mean, why they are important and how they can implement them.

Miss Jurd: A lot of our programs are evidence based. We have skills in-house here. We have a former teacher who develops our curriculum for us. We make sure that our programs are aligned to the curriculum, that we support the school curriculum and the outcomes students should be achieving, and that we are supporting the school in what they need to achieve. It is important for us to acknowledge that we are not experts in the field and we do not stray into territory where we are not skilled. We stay in the space where we can provide support and add value.

CHAIR: Mr Boyd, you talked about your own personal experiences, and I am sure many of the committee have seen your story on the ABC *Australian Story*. Many other people who have come before the committee have talked about the issues of stigma around mental health and the challenges that presents to people who are trying to come to terms with mental health in seeking treatment and recovery. As a person with lived experience, how significant do you think the issue of stigma is? Is there more we need to do in terms of trying to destigmatise mental health issues?

Mr Boyd: I think it is definitely improving. My experience was seven or eight years ago, and in my opinion it was not a common thing to talk about your mental health and wellbeing. I think it is such an important topic. With COVID, bushfires and all the different things we have had to go through in the last couple of years, it is only another reason we have to talk more about mental health and wellbeing and reduce that stigma. The more resources there are and the more things we can do the better. Like I said, that is one of the positive reasons the Broncos put their badge on the brand. That is something we can do really well because as an organisation we can reach so many. In terms of sport there is also the Rugby League aspect. When we talk about mental health, these children's heroes are going up in front of them talking about their challenges, their setbacks, their fears and how they have been able to navigate forward and build resilience. I think that is great for young people to see to really reduce that stigma.

Mrs McMAHON: You are in schools talking to young people. Can you give us some insight into the prevailing attitudes of the young people you deal with around mental health? Do you see a changing perception of mental health, specifically in relation to help-seeking behaviours? Are you seeing some things change over time? Obviously that is a goal of yours, but as you spend time in schools what are your feelings about how kids are treating it on the ground?

Mr Boyd: There has definitely been a small change. When you have been more than once to different schools you repeat things, whether it is journalling or practising gratitude. We talk about signs and symptoms and then understanding the signs and symptoms you may be able to see in yourself, loved ones, family members or friends. The kids are putting up their hands to say 'my mum, my dad, my brother or myself', so they are actually understanding these signs and symptoms. They

talk about depression and anxiety, so they understand some mental illnesses. When you talk about stigma, the more we talk about these things and the more we do as a whole, the more we will start to see it going down into the general population.

Miss Jurd: The journal Darius was talking about was actually demand driven by the students themselves. During the workshop Darius talks about the benefits and strengths of journalling and what that can give students, so they actually requested it. They responded to that by developing and creating the journals we give them as part of it. The other thing we found is that in several of the schools the students are driving activities themselves, their own wellbeing program of support, which was unexpected but amazing to see and such a great outcome. We know that a lot of students, when they are exposed to this kind of information, do take it in and they do respond in such a positive way.

Mrs McMAHON: Your organisation is probably in the best position of everyone we have had to come and talk to us about the role of sporting clubs and the role they play in the lives of young people and communities. These are often teams they join when they are very young and they stay with into their teenage years, hopefully right up to the point where they may present with mental health issues. Particularly in our rural communities, sporting clubs are often the glue for younger members of the community. How important do you see the role of our sporting clubs in providing safe, inclusive spaces for young people and also potentially being the platform for some mental health resources or counsellors within that sporting team environment? Obviously, as a professional organisation the Broncos have a lot of mental health professionals, sports psychologists and that type of thing to keep you guys at peak performance, but do you see a role in our grassroots clubs as a mental health platform?

Mr Boyd: I do. I think the grassroots level is really important. Talking about not just my experience but others whom I know and have been involved with, depending on your background and your childhood, whether you have a mum and a dad and all of these role models and whether you have father figures around in your childhood—that might not be the case, but a lot of kids do use sports and that connectivity, that trust, that supportive network. We need to have, as you say, trained professionals or quality people in these spaces because they are not just the coach, they are not just a support person and they are not just mum and dad or the help of a team-mate; they are actually people who are genuine role models for some of these young kids. Like you said, they are the glue that keeps some of these kids wanting to turn up and go to school, wanting to turn up to Rugby League, soccer or netball or going to these sporting events. It keeps them having hope, something to look forward to, having fun with your friends. Grassroots sports and exercise in general is important and a way to have some really positive support people and hopefully some strong advocates for mental health in those spaces.

Mr MOLHOEK: I am a huge fan of the work that you, the Cowboys, the Titans and many of the NRL teams do in getting involved with local schools and young people, particularly some of the work in our Aboriginal and Torres Strait Islander communities. I want to ask you a few questions around the actual program. There is a program in the education system in New South Wales they refer to as the Resilience Doughnut. Is that what this has been modelled on, or is it just a coincidence that you were talking about resilience and there just happens to be a program called the Resilience Doughnut in southern education systems?

Mr Boyd: No, that is just a coincidence. I know there is a Resilience Project as well. I am pretty sure the Cowboys run something similar to the Resilience Project. This was formed probably four years ago now. At the moment it is more of a workshop. It is something that we want to grow into a program. Based on resources and expertise, we are probably limited to it being a workshop at this point. The idea and the long-term goal is that we would love to be in schools consistently and more a program than just a workshop.

Mr MOLHOEK: Earlier in your presentation today you talked about the way you developed the curriculum or the program. Can you tell us a little bit more about how that was developed and what input you had from educators or facilitators to help work that up?

Miss Jurd: The broader program has been designed to be delivered over a term within a school year. There are resources that have been developed for the teachers, so they have resources each week that they can go through within that class space. It has been designed to align with the curriculum and it can be a replacement for a HPE class. It can actually fit into the school scheduling. It can fit into how they are supporting students. There are resources there for teachers to deliver, and we would also come in multiple times during that term with our ambassadors to do that one-on-one support with the students and deliver the workshops.

It was developed by our in-house expert from the education system. She developed it and made sure it is aligned to the curriculum so that schools are comfortable with it and they can connect with it. We do have that program developed. We are not able to roll it out without resources, but there is definitely interest and demand from schools. They are constantly reaching out for support. We go in and provide support where we can through the resilience program, the workshop that Darius does and the other ambassadors. In terms of that broader scale program, there is definitely a need and opportunity there. To answer your question, the design of it is informed by our expertise and making sure it is aligned with the curriculum.

Mr MOLHOEK: Can you talk a little bit about—I was going to say your target audience, but are there certain groups or school groups that you have greater success with than others? What is the profile of the schools that typically reach out to you wanting the program? Can you give us some general observations around how young people interact with the program?

Miss Jurd: Darius can probably talk to how the students respond in class. In terms of where the interest is coming from, it is across the board but it is also probably more so in communities or areas that have more challenges and where the schools are facing more challenges. At locations where there are other social issues happening we see a lot more mental health issues within the school with the students. That can be quite challenging, so the schools do reach out for that extra support. Our existing programs support Indigenous students, predominantly girls, through our girls academy, but also boys through our mentoring program. A lot of the delivery at the moment is supporting our Indigenous students. Having said that, we can deliver to the entire school population.

Prior to COVID we were already seeing a trend in increasing anxiety amongst our students. Post COVID that has just continued. We are seeing increased anxiety even more so, to the extent that some students just cannot come to school because of the anxiety and mental health issues they are experiencing. Through our student support officers who are in schools with those programs we are able to provide some support to those students and families and provide that advocacy as well between the student, family and school to help the school understand the broader context of what is happening with those students.

Mr Boyd: With regard to the age bracket, I would say sevens and eights are probably the ones. While I think it is ideal to get them as young as possible to learn some of these tips, tools and strategies, seven- and eight-year-olds seem to be the ones that are engaging the most, connected, understanding and listening. I think it is nines, 10s and above who start to disconnect—the ones who are starting to go through some of these different challenges of life. Being young adults or teenagers, they are the ones that I find probably need the most help and support.

Ms KING: Thank you both for coming in. Thank you for the work that you do. Darius, how do you find that young women engage in your workshops compared to young men? Do you see differences in the numbers presenting to you?

Mr Boyd: As Kath says, it is predominantly a girls program that we speak through, but a number of schools have let us talk to the whole school, boys included. The girls speak more about their emotions, thoughts and feelings, so they are probably more interactive with the content and with what we are delivering. The boys are probably a bit more stand-offish, but then I find because of my background, being a male and with Rugby League—a lot of them probably follow sport—that a lot of them might come to me after the session to have a chat or talk about the journal, get a photo and just have that one-on-one interaction. The girls interact more with the program, but I think the boys probably want that one-on-one support. They want to not do it so much in front of their peers but in a one-on-one type setting.

Ms KING: Obviously there are a lot of professional and elite sports teams based in Queensland and across the country and, to varying degrees, all have a platform that can be used to connect with young people in regards to their mental wellbeing. Has any work been done with peer sporting teams for them to look at rolling out similar programs into their catchments, fan bases or what have you?

Miss Jurd: Not to date that I am aware of. In the NRL, each club has different degrees of community departments. I think we would be the largest by far across the NRL. There is limited capacity, I guess, for us to collaborate with other clubs. Having said that, the NRL itself has programs that it develops and they provide support to our game development teams. That is another avenue of touchpoints within community. They work with schools in different communities. They do game development but within that—I think it is in a primary school setting—they have some support that they can also wrap around that sport activity. They have developed one for resilience and wellbeing as well as healthy bodies and really positive, proactive type workshops.

Mr MILLAR: My seat is in Western Queensland. Are you reaching out through the Queensland Rugby League and Central West Rugby League, who are looking at running programs? Preston Campbell has come out a lot to look at trying to mix sport with mental health and to identify. Do you reach out past South-East Queensland? Is there an opportunity to get to remote and rural areas?

Miss Jurd: Through our current programs our current footprint is predominantly South-East Queensland and northern New South Wales, but we also go out west. I think we have Roma, Cunnamulla, Charleville—that region. When we are going out there we can also do a workshop when we do our existing workshops with the schools.

Mr MILLAR: I just encourage you to get in contact with a bloke called Dave Kerrigan. He is at Queensland Health. He is running a wonderful program with mental health and using Rugby League. He is a Rugby League player out there as well. It would just be good to see. I think your program is working. I think we should just get it out further.

Miss Jurd: Dave Kerrigan from Queensland Health?

Mr MILLAR: Yes, he is based in Barcaldine.

Ms KING: A wonderful guy.

Miss Jurd: No worries. We can reach out.

CHAIR: He is involved in many great community organisations.

Dr MacMAHON: In your experience, what are some of the challenges that young people are facing? You mentioned that you are working a lot with Aboriginal and Torres Strait Islander young people. Was that a specific decision? What kinds of challenges are you seeing in that space?

Mr Boyd: Before COVID it was bullying, social media and different traumas. That is probably heightened in the Indigenous community in different areas. Since COVID, that has all been heightened. Delays in coming back to school was one. Another was anxiety. There are different needs from different students. There were school absences from different responsibilities as well. There was anxiety from home—from mum and dad or caregivers—then going on towards those children. Some of the things we were seeing before COVID have just been heightened since.

Miss Jurd: I agree with that. As Darius was saying, prior to COVID we were definitely seeing an upward trend in anxiety. Definitely post COVID that has continued and probably worsened or been exacerbated. In terms of responding to your question around the Indigenous students, we have a great relationship with the Indigenous community. They seem to connect with our brand and with our club. That is where predominantly our program sits. In terms of the issues we are seeing, a lot of those students are already coming with trauma. Increased anxiety and increased issues compound those issues. We are seeing that play out in the school grounds, whether that is through absences in that they can just cannot physically come. Another issue is: if there are concerns or issues within the family, they might then have caring responsibilities in terms of a parent or siblings which then keeps them away from school. A lot of our programs are directed at really supporting the students, creating a safe space within school that is culturally safe where they feel they can come and get supported and where people will listen and not judge them. We create that encouraging environment so they do come to school. I should make the point that schools are also very supportive. They are completely aware and cognisant of the need for support around mental health. They do what they can. Our programs support and complement what the schools do. We do not replace them. We just provide that advocacy type support for the students and their families.

Mr MOLHOEK: Just for *Hansard* and the history books of Queensland, I thought I would say that I was not happy about your win against the Titans in round 1 in 2009. I am very disappointed that you did not take up our offer to come and play for the Titans in 2011. I just wanted to get that on the public record.

Miss Jurd: Darius, you can respond to that!

CHAIR: Darius, I will save you there and rule that question out of order!

Mrs McMAHON: It was more of a comment.

Mr MOLHOEK: I wanted to know why you did not want to join us in 2011.

Mr Boyd: I am a Gold Coast boy, but whatever is in the water Wayne Bennett gives you is something special. I could not move on without him.

Mr MOLHOEK: I had the privilege of playing for Keebra Park a long time before you at Palm Beach-Currumbin.

CHAIR: I thank you both for the work you are doing. I have seen some of the good work in the schools in my community and I thank you for that. I will finish up with a much easier question for the history books and *Hansard*: Broncos or Sharks tonight? Either of you can answer.

Mr Boyd: Broncos!

Miss Jurd: Broncos!

CHAIR: Thank you very much.

Miss Jurd: Thank you for the opportunity.

HEFFERNAN, Dr Ed, Director, Queensland Forensic Mental Health Service

CHAIR: We last met with Dr Heffernan in the Qantas Club on our way to Cairns, I think it was. It was a fortuitous meeting. I am glad you have been able to get here today. Before we start, do you have a view on the Broncos or the Sharks?

Dr Heffernan: I am an AFL supporter. I can only tell you that the Geelong Cats will probably win the grand final.

CHAIR: There you go; we have got that out of the way! Would you like to make a brief opening statement? Then we will go to the committee for questions.

Dr Heffernan: Yes, I would. I thank the committee for asking me here today. I also acknowledge the traditional owners of the land and pay my respects to their elders past, present and emerging and acknowledge that this is an important area for Aboriginal and Torres Strait Islander people. I will discuss that.

I have been working as a psychiatrist across Queensland's criminal justice system for over 20 years. I have observed recently, particularly in the last couple of years, that we are now seeing not only a higher number but also a high acuity of mental illness coming through the criminal justice system. I work at the women's prison regularly, every week. Not a week goes by when I am at the women's prison that I do not interview at least one, if not several people, through the slot in the steel door while they are dressed in a suicide smock. I have to essentially shout at them for the interview and hear about the sort of trauma and misery that has actually led to them getting there and, more commonly than not, the psychotic experiences they are having at the time that have led to the way they are having to be managed. They should be in hospital beds.

It is not a failure of the hardworking and well-trained individuals in hospitals and communities and it is not a failure of the design or the elements within our contemporary mental health system; it is a failure of the system that has not grown sufficiently over the past decade. I know that you have heard that and I guess you all would support that. Essentially, it results in many individuals experiencing the recruitment of adversity that leads to the criminal justice system starting with them not being able to access proper mental health care. I essentially fully support what has been raised earlier about too few beds and the need for funding for community mental health services.

Focusing specifically on the forensic mental health system, we have provided an explanation of what the forensic mental health system does. Essentially, it provides mental health care across all the touchpoints in the criminal justice system and also works with mentally ill people in the community who look like they might get themselves into the criminal justice system. One of the advantages we have is that we have statewide visibility, but we also have visibility of what happens in services after-hours, on weekends or on public holidays because of the programs that we run. We are seeing increased numbers of mentally unwell people funnelling into the criminal justice system and increased adverse outcomes including flow-on offending. Of course, most of the people we are seeing who are coming into the criminal justice system are actually victims of violence, social adversity, mistreatment and stigma. The police are overwhelmed by mental health crises. We know from our research alone—there is a collaboration with the police—that they are receiving over 100 suicide related calls a day. That gives you an idea of the magnitude of that problem which I am sure you are aware of.

We also know that most individuals in our watch houses have substance use problems and most of them—in fact the majority—experience psychological distress. Many have mental health problems if not mental illness. We know that the prisoner populations have nearly doubled over the past 10 years and that the rates of mental disorder and trauma amongst this group are magnitudes higher than they are for the community. We have done a lot of work with Aboriginal and Torres Strait Islander people and know this is particularly the case for our Indigenous cohort in prisons.

We know that when people leave custody without continuity of care they die from suicide and overdose at rates that are dramatically higher than any other health cohort. We also know that they suffer high rates of relapse and then present to hospitals with complex health problems in the middle of the night or three o'clock in the morning in really highly expensive, service-demanding ways. We also know that they have rates of reoffending that are much higher, and of course you have heard of the revolving door.

If we judge ourselves by how we are treating the most unwell and the marginalised in our community, we are currently failing within our mental health system. While investing in the mental health problems of people in the criminal justice system may not be a vote winner, it makes complete sense from a public health perspective. It reduces bad outcomes for individuals, it reduces money that is spent on these individuals and it reduces crime. It is really a public health no-brainer.

What do we do about all of this? You heard from Professor Allan this morning and you heard Professor Emmerson and others talk about the needs of the general mental health system, so I will focus specifically on the forensic mental health system. Firstly, we have to acknowledge that there are some fantastic bits of the forensic mental health system already in place. It is a national leader. In many programs, Queensland is leading the way. We have extremely positive service elements within the forensic mental health system to build on. Where are the gaps? This is what I wanted to draw the committee's attention to. The first gap is the challenges with the statewide coordination of these services: ensuring quality, safety, consistency, equity. How do we do that? We do that with statewide coordination. I would like to draw the committee's attention to the *When mental health care meets risk* government report, particularly to the first 10 recommendations.

Secondly, there are opportunities in the prevention space. This is when mentally unwell people interact with police. We need to better support the police in real time when they are managing people in mental health crisis. We have excellent police and mental health programs, but we need to expand the role of those programs and also their hours of operations, particularly the police mental health liaison program. We can help link people to the services that they need rather than utilise the blunt instrument of emergency department, welfare checks or the criminal justice system. We have the building blocks and we have many of the services already in place in the community; we just need to link them together. We have done research that points directly to this and identifies the problems.

Then there are the co-responder models which I know you would have heard about. They seem like a great idea and there are more of them being developed. However, the problem is that they need statewide coordination so that there is consistency of the model of service delivery. The model of service needs to be clear to keep people safe and to ensure it is used in the most cost-efficient way.

The committee should also consider the mental health intervention program. This is a really important program for Queensland. It is currently under review and it would be important for the committee to consider how that review is progressing. I think this is a critical collaboration between police, ambulance and mental health in local areas and really important for the people with mental health problems.

Within the criminal justice system itself—courts, watch houses and prisons—we must first support diversion where it is possible through court diversion programs for mentally ill people. We have excellent Mental Health Court liaison services operating right now, as we speak actually, but the demand exceeds the supply. In prisons we have a nation-leading model for prison mental health services, but we are more than 50 per cent under the funding for the international standard. For Aboriginal and Torres Strait Islander people in custody and in courts, we have developed an Indigenous-led, culturally informed service—the Indigenous Mental Health Intervention Program—but it only is funded to go to two prisons in the south-east corner. It must go statewide and it also must go to the courts and the watch houses.

There is a significant gap in drug and alcohol services and addiction medicine for people in prisons. There is really an absolute dearth of these programs. It is actually ironic because it is the highest concentration of drug and alcohol problems anywhere in the state, and it is one of the most significant reasons that people have bad outcomes when they leave prisons and often reoffend.

Intellectual disability is probably the most underserviced area in the criminal justice system. We really need to focus on services for that. I will suggest some things later. We urgently need to expand the capacity for diversion into hospital beds as well for people who need inpatient care. We currently have the second lowest number of high-secure beds per head of population in the country, and we have significant difficulty getting any access to general mental health beds for reasons that I am sure you are already aware.

To finish, I will refer to a couple of other critical forensic mental health system matters. For individuals subject to a forensic order (disability), there is no dedicated community care system that focuses on intellectual disability. There is in other states, and Victoria has a model for this, but it is a real problem in Queensland and it means that people with intellectual disability get stuck in the mental health system where they are not receiving the types of care, habilitation and rehabilitation that they need.

The last thing I wanted to touch on is the gap within the mental health system that specifically manages problem behaviour. These are things such as stalking, fire-setting, sex offending and domestic and family violence. We have a start. We are developing a problem behaviour clinic, but it is an unresourced pilot and is modelled on the highly successful model in Victoria. This is something that we really need to expand in Queensland.

In summary, in respect of the mentally ill in contact with the criminal justice system, there are a large number of people who traverse in and out of the community. They are a growing number of people and they are the most vulnerable individuals. They cycle in and out of the mental health and the criminal justice systems. They often experience adverse outcomes and have high impact and cost to other services. For a mental health system to function, we really need to focus on prevention, firstly, of this problem and then also timely, evidence based services for these individuals. That is the end of my opening statement.

CHAIR: There is a lot to digest and think about there. For clarification, when you refer to forensic mental health services, are you basically referring to anybody who is in prison or the criminal justice system who has a mental illness, or are you talking about people specifically on forensic mental health orders?

Dr Heffernan: The former. In the Queensland Health submission there is a definition for the committee about what the forensic mental health system is, but essentially we are talking about people with mental illness and mental health problems who enter the criminal justice system—that is No. 1; people on forensic orders—No. 2; and also individuals who might have high-risk manifestations of mental health problems who might get themselves into the criminal justice system or on a forensic order. They are really the three. The settings in which we go are courts, watch houses, prisons and hospitals, and also we support the general community mental health system in managing and in capacity building around these individuals.

CHAIR: How would you say the service goes in terms of following prisoners as they are released back into the community and providing ongoing care and support?

Dr Heffernan: It is very difficult. I think we could do a lot better. We have transition mental health programs for Aboriginal and Torres Strait Islander people which are culturally informed programs run by clinicians and NGO services, and we also have clinician and NGO partnerships for transition programs for severely mentally ill people; however, really only a small proportion can access those because they are relatively small programs.

CHAIR: Would you say that there are issues around the style and the types of accommodation that is available to people when they are released from prison and the subsequent potential impacts on the exacerbation of mental health problems, particularly boarding houses?

Dr Heffernan: I think that is a major problem. One of the things that often gets referred to—it is a bit historical—is Maslow's hierarchy of needs. Of course, if you do not have somewhere safe, if you do not have a roof over your head, if you do not have something to eat and if you do not have some money, then the last thing you are going to do is attend a mental health appointment. I think accommodation is really critical in this setting. Yes, there is an absence of suitable accommodation in Queensland for people transitioning out of custody.

CHAIR: We visited Australian Red Cross in Townsville and were appraised of a program in the women's prison called Sisters for Change. It was a program basically aimed at putting people in custody through a mental health first-aid program. There seemed to be good outcomes. Are you aware of that program? Are there other similar things being rolled out elsewhere?

Dr Heffernan: There are. One of the difficulties in the criminal justice system is that there are lots of little programs that have individual successes but are linked to short funding cycles or are pilot programs. Also, the integration of these programs across the system is really challenging. Sometimes you do not even know that the person you are seeing is enrolled in another program somewhere and having group therapy. I am not aware of that program, but the idea that somebody might have mental health first-aid training in custody sounds like an eminently sensible thing to do.

Mr MOLHOEK: I am trying to get my head around the scope and scale of the issues that you have raised. How many people would there be involved in—do you call it the department?—who are working to address mental health issues within forensic services?

Dr Heffernan: That is quite tricky. I will explain that there are five hubs that provide forensic mental health services out of the general mental health system. Each of those has pots of money to fund FTE. I know I am going to get these FTE wrong, but it will give you a rough guestimate. We have approximately 37 FTE for courts and watch houses, I believe we have closer to 50 FTE for prisons and prison mental health services, then there is a high-security hospital and that has a whole pool of staffing—nursing staff, allied health, psychiatrists—and then there is a community forensic mental health service as well which has approximately 35 FTE employed in it.

One of the issues is that when you have five different services and different budgets spread over a number of different HHSs there are opportunities for people to change the way those services are delivered. That can be a real challenge for the integrity of the model of service delivery. Of course,

people can be distressed by the problem which is right in front of them, which might be an understaffed inpatient unit for example. It could be easy then to utilise funding for other things other than the services they are directed for, and there can be differing standards, differing models of service delivery and differing aspects in the way those services get managed. One of the things that Queensland has done is establish a statewide team to try to oversee quality and safety and standards within the forensic mental health system, but that statewide team is limited by relationships. It needs a framework to support it and policy to support it.

Mr MOLHOEK: Do all those different services come under your control as the director of the Forensic Mental Health Service, or is the structuring of them quite fractured in terms of who they report to?

Dr Heffernan: The structuring became quite fractured in 2012 with the division into HHSs, so the simple answer is no. Rather, my position has a sphere of influence in relation to forensic mental health services and I work closely with the forensic teams across the state and the executive directors in each of those areas. This has been a problem, and this is a problem that was identified in the report *When mental health care meets risk*, in the first 10 recommendations.

Ms KING: My questions and a major concern that I have go to the issue that you raised of alcohol and drug treatment for people either entering remand or commencing their custodial sentence. If I was a person entering remand in Queensland, how likely would it be, if I had a serious alcohol or drug issue, that I would be able to access detoxification and/or alcohol and drug treatment while on remand?

Dr Heffernan: In some ways it depends on the substance you are using. If you are dependent on opioids, for example, then with the expansion of opioid substitution treatment into prisons, which is an excellent thing but expanding slowly, you might have opportunities to have opioid substitution treatment. There would be very limited chance that someone would pick you up for amphetamine dependence, cannabis dependence or potentially benzodiazepine dependence unless you had really significant symptoms.

Of course, the major one is alcohol dependence. Our system is a little bit better with identifying alcohol withdrawal; however, the issue only starts with detoxification. Detoxification is going to be a major risk. People can actually get really sick, as I am sure you know, with detoxification. That is not really the issue. It is part of the treatment. What people actually need are psychological interventions for their substance use problem; otherwise they go out with exactly the same problem they came in with and, in fact, are at a higher risk because their tolerance is reduced. That is why we see such terrible rates of mortality from overdose when people leave custody.

It is a real problem. Potentially one of the major problems within our criminal justice system is the absence of—I should not say ‘absence’; I should say the scarcity of appropriate drug and alcohol services that take a holistic approach to substance misuse. Most people are not having problems with one substance; they are having problems with multiple substances.

Ms KING: Is it the case, then, that upon entering a custodial setting I would only be likely or only have a chance of being picked up for that treatment if my detox symptoms, my withdrawal symptoms, were severe?

Dr Heffernan: That is one way you will get picked up. The other way is when you go into the watch house. There are screening instruments asking people questions about their substance use. If you go into prison, the very first thing you do is have a health screen and that will ask you about substances. There are opportunities to pick up substance use in that way.

One of the issues is that if you have, for example, a methamphetamine habit and you identify as having a methamphetamine habit, there really is not the resources and skill set that would be available to provide the interventions that are required for that type of substance use problem. It applies across the board to other substances in an ongoing and appropriate way, particularly with individual therapies.

Dr MacMAHON: Dr Heffernan, can you comment on measures to help divert young people from the criminal justice system? There are recommendations to raise the age of criminal responsibility. Do you have other recommendations for young people?

Dr Heffernan: I will perhaps confine myself to talking about the area that we have involvement in, which is the Mental Health Court liaison services. This is really important. Queensland was quite advanced in the model of service delivery that it developed for young people going into detention, which is a combined mental health and alcohol and drug service, and it is a very good service. Unfortunately, what has happened is that the youth custody population has grown quite dramatically. Particularly the north is struggling to have access to appropriately qualified individuals to work in those

services. That is in the detention centre. Then there is the front end, which is the courts and watch houses. Again, there is a very good Mental Health Court liaison service, but that Mental Health Court liaison service is limited so the opportunities to pick up the large flow of young people coming through are problematic.

We are currently running a project to develop a model of service for Aboriginal and Torres Strait Islander young people in detention to try to determine how we might best support those individuals and transition them out into the community in a way that is safer and reduces their risk of coming back in and that addresses their mental health problems. However, that is a funded research project.

Dr MacMAHON: I note also that your submission talked about how youth justice reforms often occur without consideration for mental health service capacity. Can you comment on how certain recent changes have impacted on your work?

Dr Heffernan: Are there particular changes that you are referring to?

Dr MacMAHON: You have outlined youth justice reforms in your submission. Are you referring to the recent reforms that have come through the government or other reforms?

Dr Heffernan: I think perhaps the most challenging thing has been the increase in numbers of individuals. We are struggling to meet the capacity. That is really the biggest challenge. I should add that that is an area that is for the child and youth forensic services. We are adult services. I would like to make those general comments because we work very closely with them.

I will make a comment about the other area that is really important for diversion of young people. We did some research with the police, with the ambulance, with the PHNs, with people with lived experience and with Roses in the Ocean and we looked at triple 0 suicide related calls to police. We identified that a particularly high risk group in terms of the numbers was the 14- to 20-year-old age group, particularly the adolescent females. One of the things we have noticed is that it is really challenging to know what to do at midnight with a highly distressed adolescent female who does not necessarily have that distress because of a major mental disorder but might have that distress because of, say, psychosocial adversity or trauma. I think that is probably the area where we could really improve, because there are services there but there is not a linking point after hours for people to access the services that exist. Of course, the police and the ambulance are left with limited options, which are welfare checks, taking them to emergency departments or the criminal justice system in some cases—hopefully rare cases. Emergency departments are designed for major mental disorder and major illness, not for high levels of distress associated with things like psychosocial adversity or trauma.

Ms CAMM: Dr Heffernan, I want to go back to the question of the member for Pumicestone around alcohol and other drugs. You touched on the expansion of services that would provide more specialist response, particularly in prisons. Do you see that as a significant need when it comes to alcohol and other drug addiction? Who would be best positioned to lead that response of increased service provision?

Dr Heffernan: We definitely need more drug and alcohol services in prison. The models of those services are essentially—and this is a bit of a simplistic way of dividing them up—biological, where some people need detoxification and need medications for the symptoms they might be experiencing; psychological, and this is a really critical component, which is the psychological interventions which are not immediate but involve assessment and interventions; and social, which is about reconnecting people back into the community to ensure they have continuity of care, they can access a drug and alcohol service in the community and they have the Maslow's hierarchy of things that they might need.

Essentially, we need addiction medicine specialists—No. 1. We have dual-diagnosis coordinators within prison mental health services and that is a really good start, but they are a tiny drop in the ocean. We need expansion of the opioid substitution treatment so that anybody who is opioid dependent can get access to opioid substitution treatment—not just those who were on it in the community but also, really critically, those who were actually committing crimes to get substances because they were not on opioid substitution treatment but need to be on it and are using in custody.

I think essentially expanding through a workforce that includes the capacity for individual psychological intervention is really critical. I also think there are really good drug and alcohol services in the community and I think, if they could, they would expand into the prisons, but they cannot because they are limited and already overstretched. They would be ideal.

The system manager is the Mental Health Alcohol and Other Drugs Branch, so Professor Allan and his team would be responsible for oversighting that, and then there are NGOs—peer-led services—which have a massive contribution as well.

Mrs McMAHON: Dr Heffernan, I am familiar with some of those complex presenting issues within the custodial setting. I was a watch house keeper for some time so I was seeing people transition between the watch house and prison. Noting the significant percentage of people in custody who presented with a mental illness in the previous 12 months—and I dare say if it went back over the previous five years that number would be even higher—and noting that issues of complex mental health are compounded by incarceration factors, are there other jurisdictions, either within Australia or overseas, that have what you believe is a far better model for dealing with serious offenders who have mental health issues, rather than a one-size-fits-all incarceration model?

Dr Heffernan: There are a variety of models overseas and there are a variety of models in Australia. I have reviewed four jurisdictions, excluding Queensland; I obviously know Queensland's model. I have seen the models around Australia for forensic mental health services. I will preface my answer by saying that I think Queensland has an excellent model, so I do not think we need to change the model.

What you have to have is, firstly, the prevention aspects of the model—you do not want people to come into custody—and then you have to enable people to transition back out into community with continuity of care or else they will come back in. How do you reduce high prevalence? You stop people coming in and you stop people returning. You have to have both of those ends quite strong. Some of the programs that I have talked about deal with that.

Then in custody, there does need to be equivalent and equitable services that you would have in the community. For example, we have a massive concentration of people in the criminal justice system who are mentally ill. There is a huge population of people in custody with psychotic disorders, mood disorders and substance abuse disorders. They need access to multidisciplinary teams: psychiatrists, psychologists, social workers and occupational therapists in the same way that you would have in the community. I do not think it is a question of model changes—the model is there; there is not enough of the model and it has not kept pace with the enormous growth of the prison population.

Mrs McMAHON: Given the massive growth in prison population numbers, do you have an estimate for the committee of the number of those specialist services that would be provided to meet the needs of the current and potentially forecasted prison population in Queensland?

Dr Heffernan: I would be happy to provide the committee with that.

CHAIR: Take that one on notice. Can I ask in relation to the prison population with intellectual disabilities—it is quite a blanket term. I know the definition of 'intellectual disability'. Would these be people that would potentially qualify for NDIS funding?

Dr Heffernan: This is a really complex question, unfortunately. We know that there are a lot of people with intellectual disability who enter the criminal justice system—mild, particularly. When you get to moderate, it is pretty obvious. Certainly mild is a big problem. I have seen individuals with IQ scores of 55 in prison which is pretty astounding.

The NDIS has justice principles, and the justice principles make it really challenging to access NDIS funding while you are in custody. There is a Commonwealth/state issue and there is a timing issue. One of the things you desperately need when are you in custody is a way out. You need to have resources to get back into the community. Unfortunately, the justice principles—I know there is some work going on in this space—currently really limit your ability to get funding in an early or timely fashion to facilitate your transition back out into the community. Within the NDIS system, we really do not see people coming into the criminal justice system to assist people with intellectual disability. They often default to the mental health system.

CHAIR: I would like to thank you very much for taking the time to present to us this afternoon. You took one question on notice. We would like the response to that by close of business on 12 May.

Before drawing the hearing to a close today, I would like to thank Hansard for their work and thank the secretariat for their great support today. That concludes our hearing. I declare the hearing closed.

The committee adjourned at 4.16 pm.