# *MENTAL HEALTH SELECT COMMITTEE*

**Members present:**
Mr JP Kelly MP—Chair
Ms AJ Camm MP
Ms AB King MP
Mrs MF McMahon MP
Mr R Molhoek MP
Mr BL O'Rourke MP
Dr CAC Rowan MP

**Staff present:**
Dr A Beem—Acting Committee Secretary

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

## TRANSCRIPT OF PROCEEDINGS

**MONDAY, 7 MARCH 2022**

**Brisbane**

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**The committee met at 1.02 pm.**

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

I would like to introduce the members of the committee. I am Joe Kelly, the member for Greenslopes and chair of the committee. The other members are: Mr Rob Molhoek, the member for Southport and deputy chair; Dr Christian Rowan, the member for Moggill; Ms Ali King, the member for Pumicestone; Ms Melissa McMahon, the member for Macalister; Ms Amanda Camm, the member for Whitsunday; and Mr Barry O'Rourke, the member for Rockhampton. I am really pleased to say that today we are joined by the member for Bundaberg, Mr Tom Smith.

The purpose of today's hearing in Bundaberg is to assist the committee in its inquiry into the opportunity to improve mental health outcomes for Queenslanders. This hearing is a proceeding of the parliament and is subject to the Legislative Assembly standing rules and orders. Only the committee 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. I also remind members of the public that they may be excluded from the hearing at the discretion of the committee.

The proceedings are being recorded. Media may be present and are subject to the committee's media rules and the chair's direction at all times. You may be filmed or photographed during the proceedings and images may also appear on the parliament's website or social media pages. I ask everyone to turn their mobile phones off or to silent. If any witnesses have documents that you wish to provide to the committee, please ask to table the documentation while you are speaking. If you have information you wish to provide to the committee following the hearing, please write to the committee and the committee will then consider your correspondence.

## SAYRE, Mr Tim, Private capacity

**CHAIR:** I welcome Mr Tim Sayre. Tim, I ask you to make a three-minute or so opening statement and then we will go to the committee for questions.

**Mr Sayre:** Thank you very much for the invitation to appear before the committee today. I am here as a private citizen and represent no organisation, department or agency. The position paper that was submitted to the committee was written by myself during my time working for the Chamber of Commerce & Industry as the regional stakeholder manager for the Wide Bay Burnett and was submitted to not only the CCIQ management but also the Office of the Small Business Commissioner and the Mental Health Commissioner.

My role with CCIQ as regional stakeholder manager was to work with the business communities and business groups across the Wide Bay to develop awareness and uptake of government programs and available support for business. It was also my role to ensure that government departments such as the Department of Employment, Small Business and Training understood the needs and requirements of businesses, tailoring programs as required to meet those needs. My area included Theodore in the north, through to the north and South Burnett, down to Kingaroy, across to Rainbow Beach and Tin Can Bay, Tiaro, Hervey Bay, Maryborough and up to Bundaberg, with a variety of towns in between. During my 12 months in the role, I spoke with over 1,500 businesses and travelled over 40,000 kilometres. I know the roads well.

During this time, the issues regarding the state of the business community's mental health was a focus of many discussions within CCIQ and within government departments and agencies. Programs such as Beyond Blue and Lifeline were seen as solutions for mental health issues, particularly in remote or in isolated communities where health services might not be available on the ground.

Let me reiterate what I said in my report: I am not in any way an expert nor qualified in this field, and in no way am I dismissing any of the great work that is done in the mental health sector by amazing people. My comments to this committee relate to not only discussions I have had with business owners but also with professionals in the field, professionals who would tell me that they actually had not seen an increase in mental health issues, but had seen an increase in what they call situational stress. This statement is primarily why I wrote the position paper and ultimately submitted it to the committee for consideration.

To sum up the discussion paper, when it comes to our small business community, I believe we have it wrong when it comes to our messages and strategies regarding dealing with mental health. We essentially have a disconnect between the message and the intended recipients.

When I was talking to business owners, the response would often be, 'I am okay; I am just under a bit of stress.' Service offerings such as Beyond Blue and Lifeline simply were not seen as something as of value, as, 'I am not suicidal' was a common response.

Situational stress is often a precursor to larger mental health issues. However, it can be treated and managed, allowing people to be helped before leaping into the river, as I put it, by providing the tools and strategies and improving the wellbeing of people before they require more extensive treatments. I would like to suggest and even urge the committee to consider support for those tools and treatments that can assist with decreasing situational stress. To paraphrase Archbishop Desmond Tutu, we need to ensure we stop people falling into the river in the first place. Thank you very much.

**CHAIR:** One of the reasons that we asked you to come forward as a witness was that yours was one of the only submissions that actually looked at mental health issues for people managing or owning small businesses. It is in that respect that it made quite a unique contribution. I want to explore this concept of situational stress. I have never owned a business and have never run one. It seems like a scary and stressful thing to me to do, to have effectively two mortgages and often many things beyond your control. How much of the situational stress is normal practice in business? Are there ways that we can ameliorate that?

**Mr Sayre:** You are right. As someone pointed out to me once, when you own a small business, you get to make lots of choices like which 20 hours out of a day you are actually going to work. In running a small business, often it is with a partner, if you are lucky enough, or it can even be on your own. There is a lot of stress in running your own business—I do not discount that for one second—but what we have seen over the last couple of years is an increase in that stress through various measures that we have undertaken to minimise the impact of COVID. We have seen that a lot of the things that were then compounded on top of that increased the stress for business owners because a lot of things were out of their control. That is a big differentiation that we have seen between the two. Yes, there is a significant amount of stress in running your own business and there are also lots of rewards and satisfaction and so forth, but the situational stress seems to come these days from things that are more outside of their control—decisions made by government and so on and so forth which we have no real control around. We are hearing that in order to combat that, we need people to be involved in solutions to rectify that. We need to give them the tools to be able to deal with the stress to be able to manage it effectively.

We have been seeing that as the situational stress or the stress levels increase, your ability to make rational decisions decreases; effectively the light at the end of the tunnel is switched off. Due to lack of sleep, increase in cortisol and a few other things, the brain's decision-making ability decreases, so people are not able to see the way out of the forest. By providing strategies and so forth, it actually decreases those stress levels and allows people to work out a solution.

**CHAIR:** One of the things you mentioned in your submission, and I have seen it come through in various other submissions as well, is the desire to have humans involved in the service in a real physical sense as opposed to voices at the end of a phone. How do business owners who are doing those 20-hour days that you talk about get out of the shop to access those types of services?

**Mr Sayre:** That is one of the hardest things you find to be able to do. Part of it is making people realise they need to take time out for themselves. As I said, messages of, 'Ring Beyond Blue or Lifeline' and that sort of thing are not working because, 'I am not suicidal. I do not need to do that.' However, where we are finding that there are people on the ground, those services are being utilised.

I will give you a good example: in Kingaroy, the chamber of commerce down there has been working with a variety of groups on the ground to actually train business owners what to look for in their own staff and how to go about managing their own stress levels and so forth. Their programs,

since conception, have always been full. Usually they take around 20 or 25 business people at a time, usually run them every two months, and all of them have been full. That is an indication that if these services are provided, business people understand that they need to go and do it.

There is nothing worse than coming into work and finding that one of your employees who stayed back the night before, his body is still there. That is incredibly traumatic. Being able to recognise those symptoms and those signs early could have prevented some of those things occurring.

**Mr SMITH:** Thank you, Mr Sayre, for being here. Talking about situational stress, what outcomes would you like to see? You are not necessarily looking for a greater emphasis around the psychological assistance for anxiety and stress and so forth, but are you looking for government to make the tools and resources that give the basics and the principles of running a business more accessible to business owners?

**Mr Sayre:** No. What we are looking for there, Tom—and thank you for your question—is essentially there are ways and means to manage stress which are completely different to running your own business. Yes, our business owners need tools and so forth to be able to do that side of it—budgeting and understanding all the intricacies of business, and I would agree with you that we are lacking some of those in our business community—but what I am talking about here are those programs that specifically deal with managing those stress levels. One of the things that I mentioned was tai chi is a good way to do it. Excuse me while I refer to my notes because I will get these terms wrong. There are several programs that can be done. I do know my own work; I just cannot find it. I apologise for that, Tom, but I will get it to you. There are things that can be done that are outside the normal stresses of business.

**Mr SMITH:** You envisage government playing that role or connecting people to those roles?

**Mr Sayre:** It is about the connection of those ancillary services that could perform some of those tasks. There are even things that businesspeople can do on their own. There are breathing exercises that they can be doing. While they may seem a bit out there in some respects, these are simple things that have been shown around the world to work. Doing some breathing exercises for a couple of minutes a day can decrease those levels in the body.

**Mr SMITH:** How do you see that connection occurring? What does the government need to implement to be able to get that understanding and that acknowledgement out there for business owners with situational stress?

**Mr Sayre:** It is about connections between those services that could be there, and may be there, and businesses. One avenue is the Department of Employment, Small Business and Training. There might be a possibility to say on their website: 'Here are some services you might be able to include for running your businesses. There is your budget and so forth. Here are other strategies on how to decrease your stress.' It could be something as simple as that. This does not need to be overthought and overcomplicated. It can be as simple as: 'Here is the message getting out to business that you need to worry about your stress. Take care of yourself by doing some of these things. On these websites you will find a list of activities and associations you might be able to get connected with.'

**Mr SMITH:** Thank you, Mr Sayre, and thank you, Chair, for bringing your committee up to Bundaberg.

**CHAIR:** No problems.

**Ms CAMM:** I really appreciated your submission as well given the part of Queensland I come from. With the COVID impacts on mental health but also having gone through natural disasters, shark attacks and all sorts of things in the Whitsundays, there is a fatigue across our business community.

**Mr Sayre:** Absolutely there is.

**Ms CAMM:** You outlined some practical programs like Walk and Talk, which is on the Gold Coast. Do you see chambers of commerce best placed to facilitate those things across your community here? This is probably an extension of the member for Bundaberg's question. Who do you think is best placed to deliver that face-to-face connection and interaction?

**Mr Sayre:** A lot of the programs that I have mentioned do have a link into the business community. Walk and Talk on the Gold Coast has grown from strength to strength. It was started by somebody just talking with mates. The one that we have in Kingaroy is looking to incorporate that and a whole heap of other strategies as well within their SMILE program. Chambers are well connected in the business community to be able do those things and they do seem to be a natural fit.

Unfortunately, we do not have chambers all across the state. A lot of our smaller communities have nothing at all to bring them together. That is where I see a role that may be played by some of those government departments that support businesses such as DESBT.

As far as having roles on the ground is concerned, again, there may be the opportunity to fund people who work across multiple locations. Working with councils may be another option—some of those smaller councils—to bring some of those services in and work across an entire council area rather than just one individual town.

**Ms CAMM:** I think that is a great response. Similarly, when we have had natural disasters, we observe quite physical destruction and business has to go out and clean up the muddy waters. We are seeing that in Brisbane now. The mental health fatigue continues far beyond that. Do you see across your community in this region here post COVID that that recovery for small business is going to be extensive? Do you see that there is a recognition by all levels of government around what is needed to support small business to get back on its feet?

**Mr Sayre:** Yes, pure and simple. Let me give you an example. In 2013 we had the floods here in Bundaberg. We had our own version of the mud army. We had houses that were washed off their foundations and ended up in the middle of the street—all of that sort of thing. A few years later—I think it was three years—the council put out a storm warning and said, 'If you have staff, send them home early. Pick up your kids.' There was a direct correlation in that our businesses saw a significant downturn for two days. People just did not shop or do anything for two days after. That was about three or four years after the 2013 floods. That was a sign of PTSD. Anything to do with water in our community, everyone shuts up shop, disappears, takes to high ground—even these days.

Just because an event stops and we finish cleaning up the mud or we have removed COVID restrictions and so forth, there is a long way to go before our businesses get back on an even keel and are able to see a significant future for their businesses and are able to believe that they are trading as previous. That can take a significantly long time. It depends on the particular community that you are in. I was doing some work at Eidsvold, which is a small community about 2½ or three hours from here, isn't it, Tom?

**Mr SMITH:** It depends how fast you drive.

**Mr Sayre:** True—so about five hours! No. What we saw out there was a community that for the last eight months has not seen any traffic in the way of tourism. People are either sticking to the coast or they are going further out west. They are missing the middle trail. They have had no tourism. They have had no fresh investment in their communities. They were wondering whether they would be able to trade through December, which for most businesses is their most profitable month. These communities have seen significant drops in any fresh income through their towns. They are essentially robbing Peter to pay Paul just to keep going. We are seeing more and more businesses struggle to stay open. They are just closing their doors. Is that what you were looking for?

**Ms CAMM:** Yes, thank you.

**Dr ROWAN:** Thank you, Tim, for your submission and for your testimony today. I wanted to follow on about the tools and the strategies which were mentioned earlier by the member for Bundaberg. How could chambers of commerce be further engaged to assist with using those or translating those into practice, not only here in Bundaberg but in other parts of Queensland as well?

The second thing I wanted to ask was around red tape. Particularly with businesses, there is always more red tape. A lot of the stress you alluded to can be related to finances or managing HR issues or compliance with taxation obligations. Do you have any thoughts or advice that you could give in how that burden can be alleviated? We know that some of it needs to be there, clearly, but what things could be done in your experience and from what you have seen locally?

**Mr Sayre:** There are lots of ways that the chambers can work with their businesses to connect. There needs to be a drive from some of those chambers. The biggest problem we have is that the majority of our chambers are volunteers. They work in their own businesses. They do their own thing. Some of them are under the stresses that we are talking about today. That in itself is a significant issue in that the people that we are saying need to provide that leadership are suffering with the same stresses and are unable to see a way forward and are seeing their own businesses decreasing in revenue to the point that they are becoming unsustainable. That is significant.

I know that at their heart all chambers are working in the best interests of their businesses in their community. They want to see them thrive. Being able to provide chambers with links to activities that can be done and links to providers in the area that can provide some of these services that I have been talking about in the submission—I wish I could find it now. I think there is an absolute drive for

chambers and other agencies as well, such as local councils, to provide that. We could even do it through services groups such as Lions, Rotary, Apex—all of those sorts of things. I think there is a role for all of these community organisations to play a part.

As we know, the message coming from one particular area does not get to everybody. You need to hear something four times in marketing before you actually take any notice of it. We have that sort of problem as well. The more people we can get pushing these things and delivering them to others the more chance we will have take-up and the more chance we can work through de-stressing some of these people before they get to the point where they do need services such as Beyond Blue. There is an absolute role for them to play. I think the easiest way to do it is for our chambers, business groups and departmental agencies that are involved in that to start saying, 'Here are some programs and plans that you can use.' There is a definite way forward on that.

**Ms KING:** I ran small businesses myself for around 10 years, so many of the circumstances you are describing are ones I remember quite clearly. I was interested in your submission where you gave us examples of programs and stress reduction strategies done well—SMILE and the Walk and Talk program. Just to tease this out a little bit, it struck me that both of those do not seem to be talking directly about mental health or mental health challenges. That got me wondering about the impact of stigma. You have talked about the fact that there is a lot of stress in the small business community. As a former small business owner who grew up in a regional area myself, could you comment on whether there is mental ill health in the business community that people do not really want to own up to because of shame or stigma?

**Mr Sayre:** If you want to see a program fail miserably in the business community, put the words 'mental health' in it.

**Ms KING:** Yes. I am sure that is true.

**Mr Sayre:** There is a program that was put out by Beyond Blue. I found out about it after I had written the submission. It is designed for businesspeople. Every business person I have shown it to does not see the need to be involved in it because they do not have mental health issues. That is not a stigma. It is not something where they say, 'I don't want to talk about my mental health issues.' It is primarily that they do not see that they have mental health issues. As they have said to me, 'We are not suicidal. Why do I need to ring Lifeline when I am not suicidal? All I need to do is talk to somebody about a bit of stress that I have. Other than that I'm okay.' It is not a stigma. It is a case of: 'I don't have that problem.'

**Ms KING:** Perhaps you could comment on whether there is an assumption that mental ill health starts at being suicidal and a lack of recognition of the shades of grey before getting to that point or perhaps never getting to that point.

**Mr Sayre:** Yes. That is what I was trying to say. Where we are at the moment is situational stress, which is a build-up of cortisol in the brain that diminishes the decision-making process. It gets to the point where it becomes long term and that is when you have mental health issues.

I am talking about right at the start where I have a couple of sleepless nights which then turn into a week of sleepless nights. It is all about how we address where we are at the moment. I do not want for one second to take anything away from anybody who works in those fields, but we have a lot of people who just need to talk. The old-fashioned way is go and have a drink with your mate at the pub. That is one of the things that Walk and Talk does well—not go and have a drink at the pub but they get all the guys together. They have split up into two different groups. They have one for men and one for women because they do different things. Men will not talk in front of women because it shows them up as being weak and women want to talk about different things. It is primarily split into two. They walk around the lake on the Gold Coast. If somebody wants to talk, they do and, if they do not, they just keep walking and listening to everybody else. It is that stress relief in doing that activity that they are finding success in.

They had a gentleman who is the kind of guy who will always push the envelope. He has the dirty joke and the next day will come out with an even dirtier one. He has the funny pictures and always a story to tell. Halfway around this particular day he stopped and said, 'Guys, I have to say something.' Everybody is going, 'Here's another joke.' He said, 'I have to let you know that I am really struggling. I'm not sleeping. I'm starting to get really anxious about how my business is going.' That took him a good five or six weeks to get to that point where he could do that. That is where this program is really great. It gives people the opportunity in a safe place to be able to say, 'Things aren't really well and I need a bit of a hand with this. Has anybody thought about this sort of thing?'

One of the biggest complaints that we have ever had about R U OK? day—again, not taking anything away from that—and the biggest problem with R U OK? day and the reason it is not as successful as it should be is because if you ask somebody if they are okay and they say, 'No, I'm not,' what the hell do you do next? What people say to me is that that is the biggest problem with it, and it is the same thing with these sorts of things—that is, you need to be able to feel free to have the discussion and nobody is going to go, 'Oh shit. I've got to keep walking,' and head off. To answer your question, there are a large degree of situational stress levels. This is a very grey area.

**Mr MOLHOEK:** Thanks, Tim, for coming in and presenting today. I have been in a Walk and Talk group since 1996. I have a bunch of mates who walk up The Spit and back every Friday morning and it has achieved many of the things that you have touched on. What does a scalable model of this look like? What would it take to have Walk and Talk happening in every business centre or regional town or every city and town across Queensland? What does it actually look like? What would it cost?

**Mr Sayre:** I would like to say that at the end of the day I do not think it should cost anything, other than awareness of what the tools are. The hardest part in this whole thing is taking that first step, and again I take my hat off to the guys from Kingaroy, which has one of the highest suicide rates in the state. They are incorporating a whole heap of different things and different strategies to be able to find something for everybody, and I think that is part of it, but all of the things that they are doing and looking into and looking to bring in have minimal costs. It is finding those people who have the passion and have the willingness to take on one of these things and say, 'Every Saturday I'm going to go for a walk up and down The Spit,' or 'I'm going to take a walk on one of the bike tracks around Kingaroy,' or 'I'm going to take a walk down the river here at Bundy.' It is finding those people who are the enablers. That is all it really needs for a lot of these things.

There should not be a lot of costs associated with this—things on webpages and awareness out to groups and that sort of thing on how they can participate and how they can help. A lot of the groups that I mentioned before such as Rotary and Apex and so forth have within their charters to be able to help the community, not just the business community. There is the ability out there for some of these groups to take on these things without any real significant costs to government or anybody. How hard is it to say to somebody, 'Hey, let's go for a walk on Saturday?' It is not a big cost; it is really not. If you want to buy banners and wave flags and all that sort of thing, that is entirely up to you, but there are not significant costs for the essential core of the thing that we are talking about. Putting up how to do a breathing exercise and having that on a website is whatever it costs you to get somebody to do some graphic design and put it up on a website for millions of people to see.

**CHAIR:** On that point I just want to say thank you very much for appearing this afternoon. I think the experiences at the Kingaroy chamber of commerce are very interesting. The committee is going to Kingaroy, so we may actually take the opportunity to try and meet with some representatives.

**Mr MOLHOEK:** We should go for a walk with them.

**Mr Sayre:** Absolutely.

**CHAIR:** We should. Mr Sayre, thank you very much for your presentation here this afternoon.

**Mr Sayre:** No problem. Thank you very much.

## CLARKE, Ms Kathy, Chief Operations Officer, Indigenous Wellbeing Centre

**CHAIR:** I now welcome Kathy Clarke, the Chief Operations Officer from the Indigenous Wellbeing Centre. Thank you for being here. We will just repeat that the committee respectfully acknowledges the traditional custodians of the land on which we meet today and pays 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 peoples whose lands, winds and waters we all now share. Kathy, I ask you to make a brief opening statement and then we will go to the committee for some questions.

**Ms Clarke:** Yes, certainly. Firstly, thank you for the opportunity to be here today and to present to you. To give you some context of our organisation, the Indigenous Wellbeing Centre is a large Aboriginal community controlled health organisation. We have footprints in the Bundaberg and North Burnett regions. We have around 15,000 clients and deliver around 130,000 episodes of care per year across a number of services, so we can offer quite a unique perspective into mental health. We see it from different angles. We have a medical centre. We have a psychology service. We are funded for stepped care mental health. We have AOD programs funded by multiple providers, so I think for us we see it from many different angles and today we just really want to talk about our experiences. I think two of the key areas that we are struggling with in this region are complex mental health conditions, particularly with a dual diagnosis where there might be substance misuse, and also I think—this is not a new issue; it has been around for some time—affordability of community services for mental health treatment.

I will start with some of the more complex conditions. To put this delicately, from our experience—I am speaking about our experiences—we have found that the way that the public mental health unit operates is not always compatible with primary health care. There is a bit of a disconnect there. To give you some examples, we may have a complex client presenting with features of psychosis to our medical centre. This patient could be well known to our service and there could be concerns from multiple different program areas and this patient is referred on to mental health and the aim here really is to get psychiatry input and to try and get some treatment and get the patient stabilised, ideally, so they can be treated in the community. A lot of the time we find that in our experience there may be only a very brief consultation with the psychiatrist, sometimes possibly not at all. Where that happens, features of, say, psychosis may not be picked up. Sometimes we are surprised at the things that are not picked up. Sometimes the patient may be seen and then released back into the community with no further intensive treatment options, so no inpatient stays and for some reason may not be referred to the community care unit for further supports.

We have had patients who are not given a diagnosis and they are given medications such as antipsychotics. We are told by our GPs that this is causing issues for the patients with accessing PBS funded medications without that diagnosis. We also find that sometimes the communication back from the mental health unit is a little bit lacking, so a lot of the time you will have GPs without a diagnosis. They have their patients being prescribed some pretty heavy medications and really the expectation is that they continue that in the community, so that is a big issue. It is an issue for the patient obviously and it is also quite a big medico legal risk as well for our GPs, and I am not sure if this has been raised. Out in regional and rural areas you have a lot of GPs going above and beyond in a lot of different areas and stretched quite far and there is quite a high medico legal risk to them, and I think that is one of the contributing factors why it is so difficult to recruit and retain health professionals in these regions.

Just to touch on some of the dual diagnosis scenarios, some of the feedback we have from our patients and clients is that it is a little bit of the chicken and egg sometimes: what has come first, the mental health condition or the substance use? What we find is a lot of our patients and clients may be self-medicating to treat their mental health conditions and when those patients and clients are referred on to mental health quite often we are told, 'No, they need to go to rehab,' or, 'No, this is a drug and alcohol issue.' Again, it is very hard to stabilise that person to get them treatment in the community where our options for treatment are very limited. I think that is one of the key issues.

Coming from the other angle, when we finally get the patients back in community for treatment, affordability is a massive concern. We have stepped care mental health. We have Medicare Better Access, but I do not think I need to repeat the limitations with Better Access. Obviously there are only 10 sessions. From memory, I think the rebate is around $88 per session and I think the APS recommended fee for psychology at the moment is around $267. Not many providers in our region charge that amount, if any, but it is more likely to be around $150 to $165 or $170, so that is still quite a significant gap that patients need to fund to access mental health treatment and quite often they have to pay for that up-front. To my knowledge there are no bulk-billing psychologists in the region at

the moment and a lot of our patients just cannot really afford to come in to see the psychologist and then at the end of the appointment pay up-front and wait for their rebate to come back into their account. In our experience that does not really happen and it is a barrier for treatment.

In terms of other concerns around the stepped care mental health, we are funded for stream 6 Aboriginal and Torres Strait Islander services and I have to say the funding does not go anywhere near the need and the program guidelines are very limited. At the moment there is a lot of situational stress in our region from COVID, economic stress, people have lost jobs, we have not recovered and I think our rental vacancy rate still sits around 0.4 per cent. In terms of housing affordability, prices have gone through the roof here. I would say that in our experience this is probably the highest number of clients experiencing homelessness that I have seen in my 10 years at IWC. That just really further exacerbates anything that you try and do with those clients.

I think from a mainstream model there tends to be the mentality that, if you have a client who needs to see the psychologists, they will jump in the car, they will bring themselves in, they will pay for their appointment up-front, they will be compliant and book the next appointment. What we see is that, firstly, we have to find the client, and if they are experiencing homelessness we could have staff out for hours trying to locate clients. So we have to find them, we have to bring them in, we have to engage, we have to build capacity with that client. It is not just a simple, 'Here you go. Here's your appointment. Come and see the psychologist.' There is so much work behind the scenes and on the ground that is not seen to just engage those clients. For a small pot of money when you look at the outcomes the outcomes really are around number of episodes of care and I suppose value for money, but they are not really a true reflection of what is needed on the ground and what is happening on the ground.

**CHAIR:** I might jump in there and we might go to some questions.

**Ms Clarke:** Sure.

**CHAIR:** Thank you. That has been a really extensive outline of what you do.

**Mrs McMAHON:** Thank you very much, Kathy, for being here today. You touched on a number of barriers, certainly in terms of the role that GPs play. I am particularly interested in the diagnosis process. That is really kind of where referrals to organisations start. No doubt we will hear from government department reps in the health space for the region locally, but from your experience where are some of these gaps in the delivery of those diagnosis services that enables someone to start their pathway to wellness?

**Ms Clarke:** I do have to say that Dr Alicia Kohn, who cannot be with us today, would do this question far more justice than I but unfortunately she is in isolation. I think for us, where we are seeing the issue, for your straightforward presentation most often your GP can diagnosis and manage that. It is where anything gets more complex, where we need to send the referrals on, where we run into issues. We have limited private psychiatry options in Bundaberg. There are lengthy waitlists and obviously cost is a barrier. Then we obviously have the public mental health unit which we do refer on to quite regularly, but I think we are finding that we are not always getting the diagnosis or outcome that we are hoping for when the patient leaves us for that follow-up appointment at mental health.

**Mrs McMAHON:** Is that due to potentially the staffing at that public mental health unit or is it the reluctance to diagnose or it takes sometimes a couple of visits for someone's presenting behaviour to really get that diagnosis?

**Ms Clarke:** I think there are a few things going on. I think that that can be the case. Sometimes if you have only a 15-minute window you are not going to see those behaviours and you are not going to get that information from the client or the patient. I think also in our experience we found that a lot of the time carers or family members may not be included. We are not sure why. We cannot comment on that. That would go I think great lengths to help get the context and the full picture of what is going on for those clients. Where possible, where the client does consent, it would be useful to try and have more of a care coordination or case coordination approach to also utilise those services that are already working with those clients well. So, go back to the GPs, go back to those community organisations that have that engagement, so they are not falling through the cracks. In terms of staffing, that is not something I can comment on unfortunately.

**Dr ROWAN:** Thank you to you, Ms Clarke, and everyone at the Indigenous Wellbeing Centre for the work that you do. You made a comment earlier, and I know you were with the best of intent making this comment and I will paraphrase it back, that the way the Queensland mental health unit operates is often not compatible with primary care and what you then went on to talk about was the collaboration, coordination and the communication which are issues that we hear in various places so it is not unique to here. The question I wanted to ask is in relation to consultation liaison psychiatry

or outreach psychiatry that comes from Queensland Health. Given the shortage of private psychiatrists and others, has there been any consideration or thoughts to what I would term hybrid positions where you might have a psychiatry position funded, a full-time equivalent one, with half of it being in the Indigenous Wellbeing Centre and half in Queensland Health to assist with coordinating and has any thought or consideration or work been undertaken between the Indigenous Wellbeing Centre and Queensland Health to look at innovative models like that?

**Ms Clarke:** No. To my knowledge it is not something that we have looked at. We have had discussions around something that we feel could be a bit more sustainable, whether we look at local GPs who may have a special interest in mental health receiving more training in that area and then becoming a go-to referral pathway for GPs in the region to try to lighten the load. I think the issue is that finding a psychiatrist or finding psychiatrists to relocate to our region, to live here long-term, is very difficult.

**Dr ROWAN:** To add to that, what do you see as the barriers for people coming, whether they are psychiatrists, psychologists or other mental health care workers? What do you see as those barriers?

**Ms Clarke:** There are plenty of barriers. When we talk to the health professionals, one of the key things they say is that being from the cities they have their lives established in the cities, they have kids, family and they are quite committed there and we hear that is one of the barriers. We are supportive of having GPs and doctors trained in our region to try to get the commitment here. I think one thing that is quite common, and I touched on it before, is when we have GP registrars and training GPs come to this region, they get a pretty good taste of what it is like to work here and I think it is a little bit of a culture shock because it is not like the city where if your patient requires a pain management specialist you can just refer on and you have that person accessible to you. That does not happen here. The medical professionals and the clinicians are often dealing with the things that are probably a bit of a stretch for their scope, just because they have to because there is no other option. Medico legally it is a massive risk. We have GPs that go away to medico legal conferences and come back and are almost too scared to walk back through the door. They are terrified. It is just not a great situation. I think the other thing we hear is when our GPs are training the registrars they will say, 'Well, look, this is the process for referring to this specialist. You need to do this, this, this and this, but it is different when you are doing this specialty and it is this, this, this and this', and it goes on and on and on. It is really difficulty, I think, to be a health professional in the regions.

**CHAIR:** You are a community controlled organisation?

**Ms Clarke:** Yes.

**CHAIR:** Do you have staff who have lived experience of mental illness or alcohol and other drug issues working as part of your team?

**Ms Clarke:** We do, yes. We have 28 different programs and services and I would say that is common across all areas, yes.

**CHAIR:** Is that helpful in terms of staffing issues or managing workforce pressures on the organisation?

**Ms Clarke:** Can you explain the question?

**CHAIR:** Is that helpful in terms of responding to workforce pressures on the organisation?

**Ms Clarke:** I suppose to a point. I think our Aboriginal community workers are key to this community. I think there is a lot of work that goes on at that level and a lot of groundwork that even we do not see. They are dealing with things and sorting things out and linking clients with services, often sometimes before they even get to the GP. There is a lot of that that is going on from that perspective. It is the duck on the water: you cannot see their little legs kicking under the water. That is that team.

**CHAIR:** In terms of the planning and the development of your services, is that something that you do internally as an organisation or is that something you do in partnership with the PHNs or the HHSs? How does that evolve?

**Ms Clarke:** As an Aboriginal community controlled organisation we have a board of directors and we have an executive team. We have our own strategic directions. We respond to the needs of our community. We take that approach. We work in partnership with the PHN, Queensland Health and other agencies where it fits with our direction and the community need. While we have relationships with those agencies, we certainly do not go in and plan in partnership with those agencies.

**CHAIR:** If something like that were in place do you think it would help with that issue that you were talking about, that disconnect between your service and the public mental health services?

**Ms Clarke:** I think we may need to go back to basics to start with and maybe improve communication, but certainly we would be open to something like that and it could help strengthen that support for community. It is something we are open to, yes.

**CHAIR:** The services that you provide, are they mainly in urban areas like Bundaberg or do you have discrete Indigenous communities that you operate in?

**Ms Clarke:** That is probably not the easiest question to answer. We do provide services, I would say, predominantly to Bundaberg, but our region stretches to Gin Gin, Discovery Coast, down to Woodgate. We have a footprint in North Burnett and that is a huge geographical region—Mundubbera, Eidsvold, Biggenden. We provide outreach services out there and we also have an outreach office out there as well. I would say the bulk of services are provided here.

**Ms CAMM:** You talked about 130,000 episodes per year. What percentage would you see in that and does your service have any specialty response to children or young people or youth?

**Ms Clarke:** What portion are children and youth of the 130,000? That is a very good question. I would have to get back to you. I would not want to say off the top of my head. In terms of children and mental health, we do have psychologists who are specialist in children and mental health. We do have youth programs at IWC that have pretty good engagement. We do have those options available.

**Ms CAMM:** You may have to take this question on notice. You were saying you have been with the service for over a decade. Are you seeing a trend that mental health is declining or improving in young people and in youth? I am happy for you to take that on notice from a data perspective.

**Ms Clarke:** I think I will need to. I will need to get back to you on that, but I will say that we have seen in our data that a mental health treatment plan is the most common care plan that we are seeing now. That really does highlight the need. It is not your chronic disease management plan, it is mental health. That is probably as far as I can take that question.

**Mr O'ROURKE:** Thank you for your presentation today. It was very interesting. I am curious about a couple of different areas. You spoke about not being able to access psychologists locally. With GP access, particularly to bulk-billing GPs, is it fairly easy to get an appointment here in Bundaberg?

**Ms Clarke:** With a GP?

**Mr O'ROURKE:** Yes.

**Ms Clarke:** I do not know that I can speak for other practices. From what I am aware of there are limited bulk-billing GPs in the region. We offer a mixed billing model which is more common, but I cannot comment on those other services, I am sorry.

**Mr O'ROURKE:** That is all right. I was just curious in that space.

**Dr ROWAN:** Can I ask about alcohol, tobacco and other drug services broadly. What is being seen from a prevalence perspective around those substance misuse issues amongst patients or people accessing your service? As a further question to that, from a workforce perspective or other programs or models of care, what other things need to happen in the region to deal with those specific issues as well?

**Ms Clarke:** Which substances are the most common, sorry?

**Dr ROWAN:** The prevalence in what you are seeing. Are you seeing mainly issues to do with alcohol or amphetamines or particular substances or issues there and what services exist or what else needs to be done from a workforce perspective and a service perspective here in the Wide Bay region?

**Ms Clarke:** I would say alcohol, marijuana. I would have to check with our drug and alcohol clinician about the third, but I think what we really need is a local rehabilitation service that is no cost, obviously. We do have patients referred to Rockhampton and to private services and there are lengthy wait times and there is a cost involved often that our clients cannot meet so they are not really getting the services that they need and they are being managed in the community. A lot of these clients are really motivated. They want help. They want the treatment. I think that is a very difficult thing when you have to be put on a waitlist or there is not treatment available to them when they are ready to receive that treatment and that is a really key part to the process, they have got to be willing and able.

**Mr MOLHOEK:** Kathy, to you and your organisation, I had the pleasure of meeting some of your other colleagues last week during the health inquiry and also at First Nations functions at parliament. The IWC here is an outstanding example of the sort of centres we need in Indigenous health. I want to commend you on the work that you do.

**Ms Clarke:** Thank you. I appreciate that. Any member is welcome to visit IWC any time. We will give you the full tour and we are more than happy to discuss things today in person. You are always welcome at IWC.

**CHAIR:** On that note, thank you very much for your appearance today. You have one question on notice. We will need that back by 18 March. Thank you to you and all of your staff for the work over the last couple of years during the COVID pandemic. It has been a very tough time for health professionals everywhere

**Ms Clarke:** It has, yes. It has been challenging. Thank you.

**BRADLEY, Ms Robyn, Executive Director, Mental Health and Specialised Services, Wide Bay Hospital and Health Service**

**SCHMIERER, Ms Clarissa, Program Manager, Mental Health and Alcohol and Drug Services (Bundaberg and Rurals), Wide Bay Hospital and Health Service**

**WEST, Dr Roy, Clinical Director, Mental Health Services (Bundaberg and Rurals), Wide Bay Hospital and Health Service**

**CHAIR:** I welcome representatives from the Wide Bay Hospital and Health Service. I invite you to make a brief opening statement and then we will go to the committee for questions.

**Ms Bradley:** I would like to thank the committee for the opportunity to provide some information today in regards to the Wide Bay Hospital and Health Service, and more specifically the mental health service. In doing so, I would like to acknowledge the traditional owners of the land on which we meet here today and also those who we provide services to across the Wide Bay Hospital and Health Service, and pay respect to elders past, present and emerging, and also to extend my respect to any Aboriginal and Torres Strait Islanders who may be here today.

I would also like to acknowledge the lived experience of those people, their families and their support networks who experience mental illness, suicidal or problematic substance misuse because they are incredibly important part of our service and how we are designing services moving into the future.

To introduce myself, I am the Executive Director for Mental Health and Specialised Services across the entire Wide Bay. I have worked in this executive role for around 10 years, but with the Wide Bay Hospital and Health Service for around 20 years. Most importantly, I am a mother, a daughter, an aunty, a sister, a friend, and I am part of this community. In saying that, I am passionate about providing mental health services to people who are in my community, who are part of my network but, more broadly, the community in general. I do not know anyone in this room who would not have been impacted by mental health concerns at some point either through direct experience or through experience of family or friends.

I would also like to acknowledge and thank the work that our staff in mental health and alcohol and drug services do every day, turning up and committed to providing services, not only across our public mental health service but also across our partners as well, particularly during the impacts lately in regards to COVID-19 and the two flood emergencies that we have had, especially down on the Fraser Coast over the last six weeks. It has been a challenging time for both our staff and for our community more broadly, and certainly it has impacted in terms of mental health as well.

Our staff turn up every day working within the allocated resources and with the intent to make a difference. No-one comes to work with the intent to do any harm. I would like to acknowledge that this also has an impact on our mental health staff and their wellbeing. The need to support staff as we review and develop services is really important to our teams as wellbeing impacts on our ability as staff to provide those services to people in the community.

I would like to introduce you a little bit to the Wide Bay Hospital and Health Service to give you a little more context. We are an area of around 37,000 square kilometres with a population pushing, I would say, 220,000 people currently, and covering North Burnett, Bundaberg and Fraser Coast areas, as well as part of the Gladstone local government area, including Agnes Water and Miriam Vale. We have three major hospitals being Maryborough, Hervey Bay and Bundaberg, as well as a number of smaller rural hospitals and multipurpose centres. In addition to that, we have a number of community based services as well. We also provide services to the 600- to 700-bed prison at Maryborough Correctional Centre. I should have said that I am also responsible for the provision of health services within that correctional centre.

Within the Wide Bay mental health service, we provide a range of services with a number of small teams. When I refer to 'teams', I want you to understand that at times that consists of one to two staff members. We are a small service and we are stretched in providing services across a large number of areas—geographically challenged—but also a large number of services. We provide general adult community-based services. We provide older persons mental health services. We have an acute care team which is the first point of entry and we see around 6,800 new referrals every year. That is for a small team that consists of around 30 full-time employees, providing 24/7 admission into the service, 365 days a year.

We have a child and youth team which also involves some subspecialty areas around Evolve, which is attached to Child Safety; AMYOS, adolescent outreach; and Ed-LinQ. We have acute inpatient services. We have two units currently—a 14-bed unit at Maryborough and a 12-bed unit at Bundaberg. It is a very small number based on population. We recently have developed a community care unit which is a 20-bed facility for extended treatment. In the last couple of years we have also opened a Step Up Step Down facility which is about providing subacute care, more short-term, brief interventions, and we partner with an NGO in providing those services. We provide the clinical and the NGO provides other type services.

We have recently set up a Hospital in the Home trial, the first in Queensland, out of Hervey Bay which is about operating inpatient-like beds in the community. We started with four beds and we are now operating at six beds. It is about reducing the trauma of inpatient unit admission by going into an inpatient-like unit.

We have recently opened the Oasis crisis support space as an alternative to the emergency department in Hervey Bay. We also provide prison mental health services and court liaison services. We go out actively to the courts and try to identify people who are experiencing mental health issues. We have forensic liaison services, consultation liaison services to our acute hospital, and we are supported by Aboriginal and Torres Strait Islander health workers for consumer engagement. One of our most valued resources and the area we continue to grow is our lived experience. We employ roughly 18 full-time employees with lived experience in mental health, and they are imbedded into every part of our model of care currently. We also have quality, safety and other administrative processes that support our service. We are currently building a new acute unit at Hervey Bay Hospital and we will redevelop our current unit into a subacute older persons unit.

When we provide services here in the Wide Bay, we cannot be a subspecialty to everybody so we try to provide some of those subspecialties, but with the understanding that some will be based out of Bundaberg and some will be based out of Hervey Bay and we will move people in between.

We are very fortunate in that we are in the process of doing consultation on and development of an alcohol and drug rehabilitation centre here in Bundaberg—a 20-bed facility, with eight beds for withdrawal services as well. It is heartening to be able to say that, given the conversation I have heard in terms of the need there. Provision of mental health services in any context is challenging, but regionality, I think, brings an additional challenge, particularly in relation to geographical challenges. If I could provide all of those services out of one site, the efficiency would be great, but trying to provide services to all those emergency departments 24/7 is incredibly challenging.

The other matter is that we have to consider some of the other impacts in terms of the challenges. With those challenges, in terms of a regional area, they also have benefits because we work in and live in our commutes and we are committed to making those services better for our families and for our communities.

To understand the challenges across the Wide Bay in terms of mental health services, I think you need to understand our social demographic data as well. Some 26 per cent of our population is over the age of 65 compared to 15.7 per cent for Queensland. In relation to the social determinants of health and that which particularly impacts on mental health, 56 per cent of our population is in the bottom quintile for social economic indicators for area. Nearly 80 per cent of our population is in the bottom two quintiles. Some 26 per cent of our population earn less than $33,800 per year, compared to 17.5 per cent for Queensland. Unemployment is at 11 per cent, compared to 7.4 per cent for Queensland. That has a significant impact on mental health in this area. You see that in a lot of the health concerns that we see.

One in three children are developmentally vulnerable compared to one in four in Queensland. Eight per cent of residents live with a profound disability compared to five per cent for Queensland. I think we have one of the highest rates of pension here in the Wide Bay. Sadly, our suicide rate here for the Wide Bay is significantly above the suicide rate for that of the rest of Queensland, which is incredibly sad in itself. It sits at 15 per cent here in the Wide Bay. It ranges from 17 to 29 per cent. I think, sadly, as you increase rurality the figures increase as well. There is significant impact in terms of the health issues that we are seeing and we are more than happy to speak to some of those things that are emerging in terms of what we have seen over the last 10 years but, more importantly, I guess where we are sitting right now.

In terms of public mental health services, we acknowledge that we are just a piece of the pie in terms of mental health service provision and we partner with a number of other agencies that are providing specialist mental health services as well. For us to have a fluid and working system we all need to be there and be contributing to that as well. General practice is often the frontline in terms of

those people presenting with mental health distress. The GP rate in the Wide Bay is 0.7 per 100,000 compared to 1.1 for Queensland so we know that we are already starting from a base of having lower access to general practitioners. We know that sometimes that defaults to us in terms of where people cannot get access to general practice and the proportion in terms of people not being able to afford to pay the gap payment as well. So it tends to default to us.

We can see that through our emergency departments. We have seen a significant increase in emergency department presentations for mental health crises, whether that is because people defer getting help because of the cost associated sometimes with getting help or access to getting help and then it often presents in an emergency type presentation. It leads to a greater impact on our emergency departments, and we have seen that recently. We have particularly seen an increase—you were talking previously about children and youth—a significant increase in crisis type presentations relating to children and youth as well as eating disorder type presentations as well. We have also seen an increase at the other end of the spectrum in terms of older people presenting through our emergency departments as well.

If you look in terms of other impacts, the allied health rate is around four per 1,000 in the Wide Bay compared to 5.7. I was meant to be presenting at a previous inquiry last week around health and environment and it certainly has a huge impact on all those other parts of the system because when those other parts of the system are impacted obviously there are more gaps in the system. Only 26 per cent of the population has private health cover compared to 35 per cent for the rest of Queensland. There are no mental health private inpatient beds here in the Wide Bay. If people want to access a bed they have to go outside of town. Access to private psychiatrists is limited. We have some locally-based private psychiatrists, others fly-in fly-out and some of our private psychiatrists fly out to provide services as well.

The number of aged-care places per 1,000 in the Fraser Coast is 48.1 compared to 56.3 in the rest of Queensland so that is a deficit in terms of our aged-care placements, particularly when we have 26 per cent of our population 65-plus. On any given day there are approximately 20 to 25 people waiting for an aged-care placement or NDIS care in our hospitals. That impacts on our mental health service as well. We have had long stays up to a year waiting for placement in more appropriate settings. We routinely have complex NDIS clients admitted to our hospital for extended periods of time when a placement breaks down and is not successful. Providing health care requires a balance across all sectors of the health system and other disability support systems. Where one component is under pressure or unable to meet the demand it often impacts on others. I guess for us if NDIS provision breaks down there is a very thin market of people who can provide those people with complex care. If that breaks down and there are no other providers, often that will default to the health service to provide that care. There is a lack of primary care and allied health community referral options for patients and that often leads to extended lengths of stay in hospital and increased hospitalisations as well.

I am sure you are aware that there was a submission on behalf of hospital and health services, which we contributed to, and I would just like to outline some of those key issues that we from a regional perspective identified in relation to mental health services. Probably one of the biggest ones we face is workforce issues. Recruitment and retention is an ongoing challenge. There are significant delays around medical recruitment. It is very difficult for us to get a psychiatrist. It can take 15 to 20 months to recruit somebody from overseas. I think I have probably recruited one psychiatrist from Australia within the last 10 years. There is just a lack of workforce. We are currently two psychiatrists down at this end of the service and we are two psychiatrists down at the other end of the service so we are constantly covering gaps. Even getting locums is a challenge.

There is a higher demand on public services to provide services where there are community gaps. When there is a failing in one area of the service, if, for example, there is a lack of access to psychologists, it is an assumption and a community expectation that public mental health services will take that up, whereas public mental health services have traditionally been, and I am not saying that that is the case, to provide for those with complex mental health issues and I am sure you have heard about the missing middle. There is a huge gap, particularly in a regional area, and understandably so the community expects that you will fill that gap but unfortunately sometimes capacity to fill that gap is limited.

There is a decreased access to subspecialty areas, creating greater demand on local and general services. We do not have access to child and youth beds, but we have to manage child and youth presentations either through transfer out or managing them within our adult service or within our paediatric services. There are impacts of COVID-19 on, particularly as I have said, children and youth and older persons, a lack of access to broader based preventative and early intervention. That

is probably one of the key things. We will continue to have to pick up those crisis presentations in the absence of early intervention and prevention services. We will continue to have to increase the number of our beds unless we put more resourcing into that prevention and early identification. We will constantly be the ambulance at the bottom of the hill waiting for those presentations to occur.

Investments in mental health and alcohol and drug services does not meet the activity demand increases let alone population increases that we have seen. Program-based funding limits capacity for regional services to truly meet gaps. A lot of funding that is allocated is allocated within programs, and that is not just within health services, but across Commonwealth funded services as well. They are targeted funding groups and the capacity to creatively and flexibly move that funding to meet our gaps is a challenge. Then it is very challenging when we are drawing up regional plans to meet those gaps when we do not have the flexibility to put the money into those gaps.

I have talked about the missing middle—that is significant; the thin market in terms of service provision; systems-based planning acknowledging the impact of many other social determinants, I guess, in relation to a person's mental health, education, child safety, housing, disability and social services. Without the psychosocial support services that we have in our NGO sector we would be lost. That is a huge thing that allows people to live more independently within the community, but systems-based funding and short-term based funding is really difficult, I guess, for some of those organisations as well to maintain a workforce. So while we have a challenge in terms of workforce, so do all those others—Child Safety. Our NGOs struggle in terms of workforce and sustainability of workforce within that funding framework and that ongoing funding framework. Flexibility and models of care and co-commissioning of services would support regional responsiveness to service gaps and community needs in regional spaces. One size fits all does not often fit for regional areas and I think we need to be a little more flexible in terms of that. After all, the community is not concerned about funding arrangements but being able to access the right care at the right time and the right place with the least amount of complexity. We create mazes within our health system in terms of people getting access.

Whilst resourcing can sometimes impact on capacity to meet activity demands, that key factor around being able to have a workforce is that ongoing challenge in terms of being able to do that and it is not an issue for public health services alone. In finishing, the Wide Bay mental health service is committed to making services more meaningful for consumers and co-designing and engaging consumers in new services being developed and look forward to sharing these experiences further with you. Consumers are very active participants in new service delivery initiatives. I cannot say that that has always been the case but certainly as we develop models of care they are. They are also engaged in our governance framework as well which is really important, keeping us honest in terms of making sure that those services are meaningful. We acknowledge that there is a huge amount of work ahead and many opportunities and ongoing need for change to make sure that consumers and our unique communities are getting the right service when they need it. Whether it be provided by a mental health service or one of the other key services in the community, that is irrelevant to me. It is about making sure that the services are there.

**CHAIR:** Let us start with the commissioning. Do you have just one PHN covering your area or are you one HHS of many that is in a PHN?

**Ms Bradley:** We have one PHN covering three hospital and health services, so Sunshine Coast, Wide Bay, Central Queensland.

**CHAIR:** To what extent has there been attempts at co-commissioning of planning and services?

**Ms Bradley:** We have a regional plan that is in place. I think it is hard because I think the assumption is that there are a lot of services sitting out there with the PHN and a lot of funding sitting out there with the PHN, and so it created a lot of expectations, but the funding is limited and it is usually program tied and not as flexible. It would be good if it was. We have our regional plan. It is hard when services are funded within a funding framework. When that funding runs out they have no capacity and so services sometimes stop as well. Then the expectation is that we pick up where there is a ceasing of services in terms of that as well.

**CHAIR:** You mentioned two new types of services. In Hervey Bay you talked about the Hospital in the Home. I am familiar with it in terms of acute care. How does it work in mental health services? Are these nurses, social workers, allied health professionals going into homes and stabilising a patient and how is care then transferred across to the community-based services?

**Ms Bradley:** There are two ways in which it works. The person would have to be eligible for inpatient-like care. It is about intensive support. The person is assessed and they would have to have a bit of a support network around them to support them in the home-like environment. It is a

multidisciplinary team. It was co-designed with consumers as well. We have lived experience workers as part of that team. We also have lived experience carers as part of that team. We have allied health professionals, nursing and medical that are part of that team. There is a minimum of twice daily home visits supporting them in their home environment, managing from both the medication point of view but, more importantly—and it is something that I think we need to get back into our inpatient units as well—the multidisciplinary approach, that recovery approach, and giving people tools in their toolkit so that when they are without services they have strategies and ways of managing. It is probably a little bit more intensive than Hospital in the Home in a general medical sense. It goes from seven o'clock in the morning until 10 o'clock at night actively calling around to see people and seeing how people are going. You will be attending a site visit and we will talk a little bit more about that tomorrow in terms of the Hospital in the Home program.

**CHAIR:** Great. The other program I think you mentioned was a crisis service. Is that something that is designed to take people out of the emergency department?

**Ms Bradley:** It has only been open for two weeks now.

**CHAIR:** How is it going?

**Ms Bradley:** Brilliant. So far, instead of two people on the first day waiting for four hours under an emergency examination authority, they were moved to the crisis support space within 17 minutes—a much more appropriate environment for them to sit and talk. Once again it is led through a lived experience model. We have lived experience plus technical people in that space. They can be provided with an assessment, ensure risk is—once again, that is a service that we are hoping to show you tomorrow.

**CHAIR:** This missing middle we are talking about, it seems to me, in my experience, a lot of Queensland Health's community services are based around getting people, once they have been acutely unwell, back in the community and stopping them coming back into hospital. If we came to you with a pot of money and said, 'What sort of services can Queensland Health develop and design to tackle that missing middle,' what does that look like?

**Ms Bradley:** Does it necessarily sit within Queensland Health? That would be my first question. I think in regional areas, given that sometimes it is a natural default—we are picking it up now and that is why we are being spread so thinly—then we may. It may also be a co-design service with other agencies as well. I would hate to make the assumption that it automatically comes to us. It would allow us to provide some brief short-term interventions for people who are experiencing mental health distress. It is very much a model of assessment currently in our acute services and some brief short-term intervention opposed to our community care teams which is much longer term intervention. I am not sure where it would sit. If it sat with us—maybe Roy from a clinical perspective could talk to it a little bit more.

**Dr West:** It is a tricky question really because we work at the acute end of the spectrum. There is no access to psychologists in the community. There is access but the access is long waiting lists and inadequate numbers. There probably needs to be some increase in the crisis management of people in crisis where it is not warranted enough for them to come to an acute service to be admitted but to still be managed in the community. I think there is a whole range of things that could be done around centres for GPs to see mental health patients. They are not going to see a mental health patient in six minutes. They are going to make a very quick assessment and refer on. Those incentives need to change if you want that cohort to pick up more of this work.

You could look at other alternatives for mental health presentations. I am not sure what they might be—perhaps better spaces in ED departments. That may be something we have a role in as well. You can look at other models where we might coordinate with those partners and provide CL type services or some sort of co-working environments perhaps. There also has to be a lot of work done around early intervention and child and youth services if you are going to minimise this whole gap in services. It is very complex. There are many ways of looking at it.

**Mr MOLHOEK:** Thank you so much for joining us today and for the overview that you have provided. I am also on the Health and Environment Committee for the inquiry that you referred to earlier. Robyn, could you talk a little bit more about some of the labour force challenges? Dr Roy, you touched on it. The common theme that is emerging for me right across the state when you look at all of these different silos that you touched on—the connection between child safety and family services, DV, housing and all of that and then all of the impacts that that has in the mental health space as well—is that there seems to be a lot of money available but we cannot find the people. I would be interested if you could elaborate on that. How many vacancies do we have? How long does it take to get a psychologist or a psychiatrist out from the UK or another country? Why aren't we able to find more people here?

**Dr West:** For psychiatrists we have six positions here in Wide Bay north and seven in the south. I have been without a child and youth psychiatrist on and off for the last three or four years. That is a subspecialty within psychiatry.

**Mr MOLHOEK:** There is a challenge to get consistency and flow of service.

**Dr West:** Yes, we get locums for some of it. Since COVID, we have not even been able to get locums. We find that we are all covering these gaps. I am also down a rural psychiatrist. I am two positions down at a senior level. We have just gone to recruitment and we hope to fill those positions. Sometimes we have recruited and people are going to turn up a year later and they do not turn up, so you start again.

**Mr MOLHOEK:** Why does it take so long?

**Dr West:** It takes on average around 10 months. We are heavily reliant on overseas supply of psychiatrists. I would love to be able to look at what the challenges are and why we do not have internal applicants, but we do not. They tend to be city centric and not come to rural areas. When we rely on someone from overseas, they have to go through a whole process of getting an offer, going through a college assessment process, going through an Ahpra process and then they have to come here. It takes about 10 months—sometimes longer. We are at the mercy of other organisations and the time lines that they have.

**Mr MOLHOEK:** What sort of salary range is it for a qualified psychiatrist?

**Dr West:** It depends on the level and years of experience. There is a sliding scale with that. It is very good.

**Mr MOLHOEK:** What would be entry level?

**Dr West:** I do not really know everyone's salaries.

**Mr MOLHOEK:** Medium?

**Ms Bradley:** It is really hard because we have rural and remote allowances. We have private option arrangements.

**Mr MOLHOEK:** Would it be more than $100,000?

**Dr West:** Yes. It is probably in the order of $300,000 or more.

**Mr MOLHOEK:** There are two vacant positions at $300,000 just in this area?

**Ms Bradley:** At times they are filled with locums, which are then more expensive.

**Dr West:** They are almost double the cost. That is just at my end of the service. At the other end we have vacancies as well.

**Ms Bradley:** We have vacancies. We can go out to recruitment two or three times to fill a psychologist. We have to recruit from a pool. We recruit from psychology, social work, OT and nursing and hope that we can get a broad spectrum across a multidisciplinary team. If we went out to one professional, we could potentially be waiting for a long time.

**Dr West:** Retention is the other issue. When we get people here, you have to please partners. They have to want to live in rural areas. You have to be able to provide accommodation. Even to get a locum here now there is no accommodation for a locum. That delays things. It is all of those sorts of things. Attachments to families overseas or in Australian cities are another barrier for people coming to rural centres.

**Ms Bradley:** That being said, we do have 10 training positions for registrars. We are absolutely committed to growing our own because it is the only way it will work. We have taken senior medical officers from overseas and supported them through the partial comparability or substantial comparability pathway. We have a number of people on our registrar training program as well.

**Dr West:** At the moment at the junior level—and this can fluctuate either way depending on what year we are in—we have a very good junior cohort who are dedicated. We have 10 junior positions for registrars and seven positions for training.

**Mr MOLHOEK:** Are those for SMOs or for people within mental health?

**Ms Bradley:** On the registrar training program it will take them four or five years to become a psychiatrist.

**Mr MOLHOEK:** So you have 10—

**Ms Bradley:** We have 10 training positions across—

**Dr West:** No. At my end there are seven but one of them is Commonwealth funded. So there are six funded ones from us and one Commonwealth funded. We have four in those positions. We also made a decision to train GPs in their specialist training year to build our own capacity. Some of those trainees now work in our GP workforce and are really helping us out in a big way.

All of our trainees I think have come to us as an intern, RMO, PHO back into the registrar training program. I have trainees now for the first time saying they would actually like to live and work here, but it has taken a big effort to provide a very good training environment to attract people to want to be here. It is about growing your own capacity and the incentives that can support that. That is going to be really important.

**Ms CAMM:** To recruit, for example, specialist psychiatrists, you are doing that as your own HHS and liaising with them. I come from Mackay. They are doing it. Everyone is doing it across Queensland. What is the support that you are getting from Queensland Health in regard to that recruitment, if any?

**Ms Bradley:** No. We do that internally.

**Ms CAMM:** That is all done independently.

**Ms Bradley:** That is all done independently. I do believe there is a bit of an international recruitment strategy about to take place. We had to identify if we had any key areas that we wanted to go out to.

**Mr MOLHOEK:** It is a campaign that has just been launched.

**Ms Bradley:** Yes.

**Dr ROWAN:** I have a supplementary question around workforce as well—whether it be psychiatrists, addiction medicine specialists, general practitioners, mental health nurses, allied health professionals. We have touched on incentives as far as recruitment and retention is concerned. What else can be done, whether it is housing or spousal family support, professional development opportunities or even remuneration flexibility? Before you touched on psychiatry registrars who might be able to access a senior medical officer package again for recruitment and retention. Is there anything that needs to be done industrially around flexibility or support or additional things that can be done for this area and/or other things that you have gleaned over time which would be of assistance in recruiting and retaining either Australian trained health professionals or those coming from overseas?

**Ms Bradley:** I do not think money is always the answer to these things. I think it is about things like access to professional development and being able to somehow put that into the packages as well or the fast-tracking of a rural practitioner because rural practitioners often get a lot of experience really quickly. How can you fast-track people through pay levels? For example, you can incentivise them to come into a rural and regional area but knowing that you are going to have to support them as well.

When we get funded we get funded on FTEs based on—not based on this but loosely there is a National Mental Health Service Planning Framework, which I am sure you are all familiar with. There is no rurality component to that. There is no: 'What do you need additionally?' If I need to send somebody to Brisbane for professional development training, they are away for three days, not five hours. There are those components that need to be built into developing a service and being able to support those staff.

We try to do that. We try to take opportunities. We have brought a lot of training out. It is better to bring training out and to have a hundred people go through it than to send a hundred people away for training. Where we have had that opportunity we have done that recently, particularly around some of the COVID wellbeing funding that we were able to access. We are also expected to be experts in some areas where we are not, such as eating disorders. There are eating disorder specialists who are working in large metropolitan areas but our child and youth team have had to become experts in eating disorders—not overnight but the numbers have doubled here. We have provided that training.

**Ms Schmierer:** It is also about the professional capability that sits within our child and youth team. Previously we were quite heavy with psychologists. Currently we have one psychologist and the majority of them are clinical nurses. NDIS has attracted a lot of psychologists out into that world where the remuneration is much more favourable. When it comes to our internal capability, yes, we have a multidisciplinary workforce and, yes, we have psychologists, but they are limited even internally to support the treatment needs of some of these specialist areas.

**Ms Bradley:** That is the thing. The education department are now rolling out psychologists as well into their schools, which is fabulous but that drains them from our workforce.

**Dr West:** In terms of medical workforce, having a medical school is going to be a great opportunity because really it is about tapping into your local resources, isn't it? There needs to be some incentives to take medical students and put them in rotations through rural centres. We get a large intern cohort of students from UQ coming to Bundaberg because they actually want to stay.

**Mr MOLHOEK:** Did you say you have one or you are about to establish one?

**Ms Bradley:** Yes.

**Mr MOLHOEK:** It has just been established.

**Ms Bradley:** Yes, with Central Queensland.

**Mr MOLHOEK:** In Central Queensland or Bundaberg?

**Ms Bradley:** Central Queensland, Bundaberg and University of Queensland. It is the first intake this year. There is a joint commitment to rolling out medical students. It is incredibly exciting. There will be a number of people from rural areas going into that training program as well. That makes a difference. We have allied health professionals already coming through the university.

**CHAIR:** Nursing.

**Ms Bradley:** Yes and nursing.

**Mr MOLHOEK:** Do you have a purpose-built facility at one of your hospitals? Have they built accommodation?

**Dr West:** We have a rural medical school attached to the HHS.

**Mr MOLHOEK:** Will we be seeing that tomorrow?

**Dr West:** No, because they are here. You are going south.

**Mrs McMAHON:** I wanted to touch on workforce issues but in relation to managing workforce burnout, which you mentioned, and the differences for the workforce in a regional area. You said in your opening statement that you are a local person, you work in health and this is your community. In a big city the likelihood that the person you are dealing with is someone you know is highly unlikely. However, in our smaller communities, the likelihood of someone having to put their hand up and say, 'I'm having issues,' and then potentially dealing with a system and a group of people who know them has very different influences on someone's ability to seek help. How do those small communities or smaller communities deal with some of those closeness issues but also how do you manage your workforce in terms of burnout? It is a highly complex environment that you are working in. You are under stresses and there is that level of local knowledge that perhaps we do not have in our bigger urban centres.

**Ms Bradley:** I think it is an incredibly difficult issue and it is probably one of the reasons that we do not see a lot of new graduates going into mental health services. Working in a regional centre—and I have worked even smaller, Charleville, back in the day—I know what it is like to live in a small town and have a memory of what it is like to lose a person in that community that you have been seeing and the impact that that has on living in the community. I see the impact of social media campaigns against our mental health staff and the impact that that has on people turning up to work and doing their job. We have created in our health service a WIG, a Wellness Interest Group, not run by management but run by staff trying to create a positive workplace culture and a supportive workplace culture. If you go out and talk to our mental health staff they will all be able to talk to you about secondary trauma associated with the work that they do and from the trauma of some of the lives that they hear about but also from, unfortunately, adverse incidents that may occur or from aggressive incidents that may occur and have occurred to them in the workplace. We absolutely need to look at ways that we can support our staff further, and that comes to part of that workforce strategy as well. We need to make sure we are looking after staff wellbeing as we move into developing new models of care, and putting lived experience into that is really important as well.

**CHAIR:** We will go to the member for Pumicestone for a question.

**Ms KING:** There are just so many questions I would like to ask. You have talked a lot about the grow-your-own approach. In my other committee work with the Health and Environment Committee—I think you said you presented to them last week?

**Ms Bradley:** I was supposed to be presenting but unfortunately flooding prevented me.

**Ms KING:** And I was supposed to be there but flooding prevented me.

**Mr MOLHOEK:** It was great anyway. I was there.

**Ms Bradley:** It would have been better.

**Ms KING:** I wanted to touch on the grow-your-own workforce initiatives that you are clearly undertaking, and you spoke about how much you value that pathway to building a resilient and sufficient local workforce. I wanted to ask about that in relation to Aboriginal and Torres Strait Islander mental health workers and whether you have any particular strategies or approaches to try and grow your Aboriginal and Torres Strait Islander health workforce in the mental health space.

**Ms Bradley:** It is an area that we need to develop further. We probably are fortunate in that we do have attached to our mental health services Aboriginal and Torres Strait Islander health workers, but not enough, and we need to look at better ways of engagement, of working with our partners in terms of that. I think there are opportunities. I think it is probably a bit siloed in terms of you get referred to a service and you see the service and you get referred back. We just got some matched funding through Queensland Health to, particularly in our rural areas, provide some services out there and we have invested in a senior Aboriginal and Torres Strait Islander health worker to start helping us work and mature towards that and obviously as part of the health equity planning, which we are currently as an HHS undergoing, mental health will form part of that health equity planning. The community consultation certainly brought up some issues around mental health and access. Do I have the solutions? No. Do we need solutions? Absolutely, but I do not think that they are solutions that I can generate; I think they are solutions that have to come from the people.

**Ms Schmierer:** I think we need to acknowledge some entry-level access into our workforce as well. To be able to grow our own, we need to be able to open up traineeships, apprenticeships and graduate level, and we do in the health practitioner level. We have HP3s graduating from universities coming into our workforce. We do not for registered nurses but into our inpatient unit, our acute, we do but not into the community space, so they come in at a clinical nurse level which is an experienced higher grade, and that goes across the stream. Even for our administration officers we need to create more traineeships and more pathways in so we can promote more of the grow your own. I think there even needs to be scholarships. My previous experience in rural areas is providing a bonded scholarship, so people would do their undergraduate and then have two years into a rural location and before no time we had them married off and they were staying. Those kinds of supports into the workforce to provide opportunity would be great.

**Ms Bradley:** It should not be about having Aboriginal and Torres Strait Islander health workers; it should be about having Aboriginal and Torres Strait Islander social workers, psychologists, occupational therapists, psychiatrists, nurses. That is where I think there are opportunities with the medical school in terms of getting people in to those sorts of pathways, and that is where I see the development going rather than assuming that we have to have Aboriginal and Torres Strait Islander health workers and we have to have Aboriginal and Torres Strait Islander professionals.

**Ms KING:** Following up from that, again, just to refer to what we have been hearing in our health and environment inquiry, we have been told over and over that the trainees, medical students, allied health students and nursing students who come from regional areas have a very different demographic to the people who might end up here briefly who originated in the metro areas. They were described as older, often having caring responsibilities. We heard recently that many come from underground jobs and then want to transition into the health workforce. Do you have any further information to add to that about the people who might come to you through your new medical school? How are they different to metro people? I know it is early days, but even your impressions would be useful.

**Ms Bradley:** I guess it is such early days that we have not seen anyone come through, but certainly in the regional areas you get a mature workforce in terms of your nursing workforce. I think that can be a good thing because they come with a level of experience. Particularly in nursing, they may have come through an AIN/enrolled nursing kind of framework. In terms of allied health, we are probably seeing a lot younger allied health. I would not say that we are seeing necessarily people going back into the allied health workforce. It is probably a bit of a mixed bag and we have not really seen what has come through the medical school and we probably will not yet for a while—seven years or five years.

**Mr O'ROURKE:** Last week I had the opportunity to meet with the new interns for Central Queensland and it was interesting to discover in discussion that the new interns who are based in Rockhampton do not get a credit towards their debt but if they go to Yeppoon, for example, they do—that is, if you do X number of years at Yeppoon, your debt is reduced—which really surprised me. I am just curious: in this area, is there a rebate that the federal government gives to your medical interns to be located here?

**Ms Bradley:** Not that I am aware of. Generally speaking, it has been linked to scholarship type arrangements and rural placements but, no, not that I am aware of.

**CHAIR:** Would scope of practice issues assist in terms of the workforce? Is there a role for counsellors in the public health system?

**Ms Bradley:** It is really hard. The public health system has been very, I guess, narrow in terms of its professional scope. I do not know how that would sit from a regulatory point of view, because obviously we are very governed by Ahpra, although we do have social workers who are not governed by Ahpra but by another authority. Is there scope for a different workforce? I think there is. We have seen that through lived experience. I would not create a model of care now without the voice of lived experience and lived experience workers sitting within that model of care, and I think we have seen huge benefits. I know that a lot of people say that lived experience should sit separate for public mental health services; I would say it brings a connect that I have never seen previously in terms of it sitting as part of a public mental health service because there is a connection and often it is our lived experience—and you can talk to that—that makes a connection between the clinical in that space.

**Dr West:** We have a peer workforce at our continuing care unit and I think that the success of the whole unit is in large part due to that because they are spending a lot of time with clients and there is a whole different conversation that happens. It has really broken down a lot of barriers between clinical staff and patients and increased communication across that group and our clinical outcomes.

**CHAIR:** Just taking you down a totally different track, you have mentioned that there is an increase in older people presenting. To what extent are you able to provide service to people who are residing in aged-care facilities?

**Ms Bradley:** It is very limited. Once again when I say we have an older person's mental health service, we have, I think, three staff at this end and four staff at the other end, but we are about to develop a subacute older person's unit in Maryborough, so it is a small team. Our ability to outreach is somewhat limited, but if we had a referral, yes, absolutely we would still see somebody. Our ability to sit within a facility and to actively look at what is happening within the facility would be somewhat limited, but certainly we would take referrals from that but there are some limitations.

**Mr MOLHOEK:** I am just curious about the Step Up Step Down facility. In the notes I notice you have a 10-bed facility, but it is designed as a diversionary centre. Can you tell us about the model? Is that a separate building somewhere? Is it a block of flats? What is it?

**Ms Schmierer:** It is. It is a 10-bed brand new purpose-built facility that lives out in suburbia. It has 10 beds and is in a model with a non-government organisation mined in this community, so it provides both step up and step down and it is about avoiding a hospitalisation and it is also about transitioning from an acute admission back out into the community. On average it is about a 28-day length of stay, which is different to an acute inpatient unit, and then different to a community care unit, which could potentially be up to about two years.

**Mr MOLHOEK:** How does, say, the cost per bed night run in that compared with, say, bed nights in a mental health unit at the hospital?

**Ms Schmierer:** I cannot give you figures, sorry.

**Ms Bradley:** No, and I probably cannot give you the exact figures. I do not know that you can compare apples with oranges, because one is subacute and it is not providing that level of intensity. It is not a sleepover. There is a support worker who sleeps over in that kind of facility as well, so it is probably not comparable. The less acute the facility the less cost it takes to run, and once again this is also a model between a clinical and an NGO as well.

**Ms Schmierer:** Yes, so it is staffed seven days a week 24/7 but with a sleepover night shift and the clinicians or the practitioners who are there most of the time are mind practitioners, so they are community mental health practitioners. In relation to your question about counsellors and whether they have a place, they have a place in other models, but the HHS provides a clinical inreach team, so we have clinical nurses and medical officers and social workers who provide treatment clarity and liaising back with the treating medical officer into that facility.

**Mr MOLHOEK:** Chair, perhaps that is a question on notice that might be more appropriate to the Department of Health, but it would be good to get the figures on how it operates.

**Ms Bradley:** Yes, we do not know, but the Community Services Funding Branch, which is part of the Department of Health, has a contract with regard to that, so we could not tell you the—

**Ms Schmierer:** We do not know the contract.

**Ms CAMM:** You mentioned the flexibility and the co-commissioning required for a regional response. What are the barriers for that right now? You talk about regional planning. You sound like you are doing the best you can with what you have and innovative responses that reflect the demographics in your community, but what do you need to help facilitate that more, whether it be from state or federal funding or agility in agreements and frameworks? What is it that you need?

**Ms Bradley:** I think it is that flexibility around funding. I can tell you that where we see success in services—this is from my perspective, and I am a bit selfish because it is about making sure our consumers have the services they need as well—is when there is a connection between the NGO and the health service in terms of providing care. NGOs are funded specifically to target some of our consumers, and that works really well. We have Way Back services working currently, where we identify the referral pathway and we work collaboratively around that. We work with other organisations, NGOs, both Bridges and Impact in regards to particular program areas where it is about integrated care and talking to one another.

Where the funding requires you to have that facilitated interaction and communication, it is much easier to do because there is a commitment between that happening. That is not to say that where there is not a funding agreement we still cannot have that relationship, but it does make it easier and it gives us all accountability because it gives us service accountability as well. In terms of flexible funding arrangements, sometimes funding is tied to a particular program and that program may not necessarily be meeting the gaps that we have identified as part of our regional planning but we cannot change it because that is the program that has been purchased. It would be really lovely to say we need more psychological intervention services. A lot of programs are funded for care coordination. It would be really good to get more services on the ground—psychosocial support services, psychological support services—that benefit the consumer.

**Dr ROWAN:** Ms Bradley, in your opening remarks, you talked about acute inpatient unit beds, with 14 in Maryborough, 12 in Bundaberg and 20 extended care beds, just as an example. I do not want to lead you in any way, but is that sufficient for your current population? What is actually required? I do not know whether Dr West wants to answer that. I am trying to get an idea of whether there is a gap and if there is what it would be.

**Ms Bradley:** Based on the National Mental Health Service Planning Framework, we certainly are short in terms of beds, particularly in that older persons. We probably do not have the population for young people, although I would say that the number of people we are sending away is significant. We are building. You will see tomorrow that we are building a new 22-bed acute unit. That will be an additional eight beds, because we will then recommission Maryborough to subacute older persons beds. That is great to have the investment in bed-based services because it is needed and we feel pressures. Part of the reason the Hospital in the Home was developed was because we wanted to deal with the fact that we did not have beds when we needed beds, and this was an opportunity to provide beds in a more innovative, creative way. That being said, yes, we need more beds but the beds are not necessarily always going to be the answer. If we frontload, then we may not need as many beds. If you go into the prevention and early intervention space, then hopefully we will not need the beds going into the future.

**Ms Schmierer:** It was in response to some bed needs and pressures that the Hospital in the Home model emerged and we needed to be innovative in finding how else we could keep people at home but get them treated as well.

**Dr ROWAN:** Does that apply to alcohol and drug beds for detoxification and rehabilitation as well?

**Ms Bradley:** We have had nothing in that space in terms of bed based but we will in Bundaberg. That is a service for the Wide Bay. That will be the 20 beds plus the eight with rural management beds as well.

**CHAIR:** I would like to thank you very much for your presentation here this afternoon. I believe there was a question taken on notice. Members may have additional questions that they would like to ask you.

**Mr MOLHOEK:** I think that question is really a question of Queensland Health.

**CHAIR:** I suspect it is. On behalf of the committee, I would like to thank you for appearing today and we would like you to take our thanks back to all of your staff. It has been a very difficult two years for all health professionals and we would like to thank them on behalf of the Queensland parliament for the work they have been doing.

## BEER, Mr Steven, General Manager, Health and Support, Impact Community Services

## SARAH, Ms Sharon, Chief Executive Officer, Bridges Health & Community Care

**CHAIR:** Welcome. I would like to thank you both for being extremely flexible today. We apologise for the delays caused by the storms that kept us in Brisbane and the impact on flights. I invite you both to make a brief opening statement of three to five minutes and then we will go to questions.

**Mr Beer:** Thank you for giving me the opportunity to talk. Impact Community Services is a community-based not-for-profit organisation here in Bundaberg with the mission to improve lives. We do this by providing a whole range of services—employment services, parental support, rural health services in the Discovery Coast area, NDIS support, as well as mental health supports. Our mental health journey started when we were successful in gaining a PHaMs contract—a Personal Helpers and Mentors program—in about 2009. We then went on to provide the Partners in Recovery program, the PIR, as well.

Currently, we have a range of services. Funded through the PHN, we deliver streams 1, 2, 3 and 4 in the Stepped Care service delivery, the National Psychosocial Support and the Commonwealth Psychosocial Support in the South Burnett, and the Continuity of Support Programme as well. We also deliver the peer group support program funded through Queensland Health and the Family Mental Health Support Services program, which is for young people who are at risk of developing mental illness. That is funded by the Department of Social Services.

In terms of looking at ways to improve mental health outcomes for people living in Queensland, I believe that simplifying the intake and referral system is vital to doing this. The amount of hoops that we make people jump through is incredible. If somebody, say, in the Discovery Coast area needs to get a GP referral into one of the PHN programs, that sounds pretty easy, but when you live in a district of over 6,000 people with 2.5 doctors that is not possible. So they have to travel into Bundaberg or Gladstone to get a GP appointment to then go into a centralised intake referral system. Currently, we are looking at about a six-week turnaround for those to be processed and I just do not think that is acceptable. When somebody reaches out for help they need help now, not in six weeks time. Then with other programs you have to be a part of something else to get into them, but I think it should really be about that no wrong door approach—where you can walk in and get some sort of service, even if it is to lower the levels of anxiety and give that sense of hope and safety right here today, not later on.

I think consumers need choice of service delivery. I do not know about you, but if you have ever eaten at a restaurant and had really bad food you tend not to go back. If you have been to a doctor and it has not been good, you tend not to go back. It is the same here. I think everybody needs to have some sort of choice—that is for sure.

I heard Robyn speak previously about NGOs working closely with their clinical sector. I think that that is really important. We have had great success when we work in collaboration with our psychosocial support programs and the clinical service with the HHS. We are fortunate in Bundaberg in that we tend to have professionals who do work well together. I have banged on about this for years. We have a great relationship with the mental health unit at the hospital. We have great relationships with child safety. We have great relationships with the Child and Youth Mental Health Service as well as Centrelink. That is unheard of in most areas. I think that that needs to be replicated. We do not have that same level of collaboration in the South Burnett. We have to work at that constantly.

The other thing that is important to increase outcomes for people with mental illness is to start to educate the public on how to stay well. Prevention is better than cure. We all know the slip, slop, slap campaign. We know how to prevent skin cancer, even if we choose not to do it. We do not necessarily know how to prevent mental illness and yet some of them are the simplest things. Earlier I heard Tim talk about Walk and Talk. Promoting those sorts of things to hopefully nip things in the bud or give support to people before they spiral out of control is important. My call to action is to work with what we have, but work more effectively and in collaboration to get the best outcomes.

**CHAIR:** Thank you. Sharon?

**Ms Sarah:** Thank you, Steve. I am going to agree with you on a few things here! Thank you for allowing me the opportunity to come and talk to you today or to hear my voice. I have been involved in the mental health sector for about 30 years. I am a psychologist by profession. I have worked across the spectrum. I have worked in the hospital and health services, in private practice, and I have been the CEO of Bridges Health & Community Care for 20 years. We were the first community-based

mental health service in the Wide Bay region. My job prior to that was community development officer specifically for mental health. Setting up services and understanding what the community needs are is pretty much the foundation of what we do and who we are.

We are also the first ever drug and alcohol treatment service to be community based. Again, we have done very much foundational work and have a long history of relationships and relationship building. Our footprint is throughout Central Queensland as well as—Wide Bay, rural communities, North and South Burnett. We have post prison services specifically for people with mental illness in the Central Queensland region and also general offender services for people on parole as far as out as Dalby and all the way down to the Sunshine Coast.

Similarly to Steve, the difference with us is we do have offender services, so pre and post transition services. We are obviously a drug and alcohol treatment service. We are the largest provider in the Wide Bay region. We are just about to expand into the Central Queensland region. We also do stepped care, community-based mental health services and hospital services funded by Queensland Health and the PHNs. We are also a specialist disability employment provider specifically for people with mental illness. If I had time, I would have a lot to say about that in terms of the service model, but that has been addressed.

With a background in community development, a passion for the sector and advocacy for better services for people with mental health presentations, I am across all the different reports and the different inquiries. Our organisation will be contributing to the committee as a member organisation of MIFA and also as the chair of the Queensland Alliance for Mental Health. I looked at some of the submissions that have already done and looked at the difference. I suppose it is the localisation and the regional issues are the difference, which is I guess why you are here.

One of my concerns is that productivity highlighted the need for planning at a local level. I can tell you that that is not happening at the moment. It used to happen. We used to be part of strategic planning groups and committees. Now we just sit in on stakeholder meetings where we give updates of what we are doing. We have been taken out of the planning process for our region. Those local regional plans are being done by your HHS, the PHN and the branch. Our voice is not getting heard as it had before. Has that made a difference? I do not think so. I think things happen anyway—policy happens, our policy happens. From a regional perspective, models of service delivery are rolled out statewide and federally regardless of whether they are fit for purpose for communities, and that needs to be addressed.

One of the biggest impacts for us in the last couple of years has been the loss of community-based mental health funding which has transitioned to the NDIS. That is no surprise. That has had a significant impact on our viability and sustainability, yet the people still keep coming. We would provide easily double the number of services that we are funded for. If you fund me for 500 people, I will deliver on 1,000. We do not get any more money for it. It is not about the money; it is about the demand for service and whether you have the capacity to provide a quality service. There is a mismatch between the service models and what they want to do and what the customer needs. That varies and does not always fit into a model of service delivery. Catering for that and being flexible for that needs to be embedded into policy, but there is really good programing and clinical governance as well.

One of the more recent concerns for me is a reduction or nil funding for overheads for NGOs. They want us to have good clinical and program governance, but they are reducing it or been unwilling to fund it. That has happened this year. That blows my mind in a COVID world and a world where we have so many more overheads than we ever had before, because we have the whole risk management that we need to do. I am a little bit like Steve in that the customer journey is the critical issue. That is where your complaints come from. When you hear from people with a lived experience, they will talk about their journey. For some of it will be great and for some of will work well, but it is the timeliness of service that is the issue. When someone reaches out, gets the courage to go somewhere and talk about their story and you do a comprehensive assessment and say, 'That's great, I am going to make some suggestions and we will get back to you tomorrow,' it is that gap, that critical time, when people reach out for help. You cannot have people on tap all the time, but when we work most successfully with the HHSs is when you have the right staff with the right attitude that it is all about that customer journey that says, 'You know what? I am working with Bridges. How about I reach out to see if someone can talk to you now before you leave the building, before you potentially walk out the door and go, "I give up."' I can tell you that that is what happens time and time again.

Where we have introduced that process, it has worked. The reason it does not consistently happen is because the assessments, whether it is hospital health services or GPs—GPs are time poor but need to look at their processes—are within a hospital health service system. When an NGO

says, 'If you call me, I will come down there and I will make myself available'—if it is critical enough or we will find someone—and they do not pick up that offer it is because the decision on what to do with that client is not made until the next day when they have their clinical reviews of who presented the day before. It is a simple solution and it works when you have the right people that you are working with, but it is not consistent and not embedded in policy. They talk about confidentiality saying that has been the issue. If you say to the client, 'Sorry, we are not going to put you in hospital. We think there is a community organisation for you. How about we link you with them now?', we know that works. We know that from suicide studies.

The NDIS is not fit for purpose for our client group. I am absolutely horrified at an unregulated industry and unskilled workforce. You can have your next-door neighbour who is your best friend be your support worker and get money for it. You can have a recovery coach providing services for psychosocial disability and not be qualified at all. It is an unregulated, dangerous industry. As a clinician, it just shocks me. I see new graduates—psychologists—setting up businesses straight out of university with no supervision. You need supervision if you are registered, but who is watching you? Who is providing feedback as to whether you are making a difference or whether you are actually doing harm? Then there are workforce shortages, which are massive for us two; but I will finish there.

**CHAIR:** Thank you both. Let us start with the commissioning and the planning of services. You made some big statements there. We talk about that missing middle, but Steve referred to the missing front door in that the GPs start there and there is not the time to get through it in a six-week period. If we were going to look at a proper planning framework at a local or regional level, what would that look like from your organisations' perspectives?

**Ms Sarah:** Steve and I were part of those strategic planning groups and those governance groups in the past. There was the community reference group and then there was the stakeholder reference group, so more the decision-makers. I was a member of the other one, but I chose to go to the higher one. In terms of the PHN you had the community council and you had the clinical council. They only have clinical councils now. That is part of the problem. We are still working in the clinical model. We are not working in a community-based, person-led, person-centred, consumer-customer service model. We are not focusing on wellbeing. The system is risk-averse, as it should be, but to the point of if it is not working, it is not working. It is the old adage: keep doing the same thing the same way and expecting a different result. It is not happening.

**CHAIR:** The point of confusion for me around that statement is that on paper the NDIS is meant to be exactly what you described just there, which is a person-led, person-centred model that puts the person in charge of purchasing the services that they need. You also described this afternoon—and I think you are correct in your description—an industry where we have people with low or no skills delivering services to people who do not understand what they need nor how to purchase it.

**Ms Sarah:** People are vulnerable. You are working with vulnerable people who say, 'I want my best friend to be my support worker otherwise she will not be my friend anymore.' I have seen people go backwards. Like I said, I have been doing this for 25 years. I have seen people who used to clean their own house and used to have a part-time job but now have health conditions, are overweight, have a permanent house cleaner and are not living their best life or flourishing at all. It is devastating. I am not sure whether that is the brief for the committee or whether it is more around what is happening in Queensland. I can only talk about the Queensland context, although being a member of a national advocacy group I know that these are not unique problems.

The issue for us in Queensland is that I know we have Hospital in the Home, CCUs and stepped care, but they all are still managed in a clinical model. They are all still led by the same thing. I am a clinician but I work from a community-based position where the door is open. We do no wrong door. That is absolutely what we do with our drug and alcohol and mental health services, and it works because the person does not have to navigate different services or different providers or go out the door. Having stream 4 or stream 3 all collocated with a mental health AOD absolutely works because the person just says, 'That is good, I have multiple appointments.' One of the issues for some NDIS customers is that they now all of a sudden have to go to so many appointments because they have so much money to go to things. Do not get me wrong, there are some good things with it, but a lot of it is babysitting instead of recovery focused—that is my professional view.

**Mr Beer:** I think with the NDIS it is interesting when you see somebody with a mental illness receive a package and they go to a service provider for NDIS and they get somebody that is really good at supporting people with an intellectual disability. Mental illness is not an intellectual disability. When you go to enforced boundaries within service delivery to work to a recovery type model, people with mental illness can be master manipulators with some of their behaviours. Some of their

behaviours are very difficult: 'But if you don't take me shopping I'll go to the next service provider. That's okay.' So you as a casual disability support worker working for an organisation, if your clients leave your hours reduce.

**Dr ROWAN:** As a follow-up question to the question from the chair, is that an issue with the standards or the quality framework of the NDIS? In other words, as the chair said, the NDIS framework was supposed to be around the customer or the client and then purchasing from one of those providers, but is the issue that vulnerable people within the overall NDIS framework, the standards of what the providers need to be or the quality framework that is being applied, that it is lacking in some respects so that people are purchasing or getting things through that because there is not a standard being applied to what some of those providers or service operators or individuals are offering?

**Ms Sarah:** You only have to be accredited under the NDIA if the services are NDIA managed. The NDIA will tend to manage part of a plan or even sometimes the whole plan for somebody that is complex and vulnerable, but they do not represent the majority of clients you get through the NDIS for psychosocial disability. This is specifically psychosocial. If they are self-managed or plan managed, plan managed can be just a bookkeeper, an accountant who knows nothing about service quality for people with mental health issues, then you do not have to be accredited.

**Dr ROWAN:** To me that sounds like you have unaccredited services. You have a huge gap where people are not accredited, they are not under the NDIA and the person who is purchasing that would be getting it from unaccredited people and may be vulnerable and at risk.

**Ms Sarah:** Absolutely. It is shocking.

**CHAIR:** Steve, you talked about that initial referral and cleaning up the referral process and people not having to wait for six weeks. Currently GPs are a point of entry. If there was another way to do it, what would be your thoughts on how we might handle that initial contact and diagnosis and then referral to the right treatment?

**Mr Beer:** They are not even getting the diagnosis at the GP. They are just getting a referral or a care plan, but the referral is in there. When you go into the intake system they will assess the client over an eight-day main assessment and service providers can do that. There is no reason that they could not walk in to Bridges, have an assessment, they say, 'Yes, you meet the criteria for these programs or we will deal with you in a different program', whatever that might look like, or, 'It is actually really for a service provider over here.' I think when you go to the GP, whether they bulk-bill or not it is still coming out of the pocket of the government. Then they go into the central intake system. Where is that funded from? There again, it is more government money. We are just going through all these steps and it is all funded from the government, but just prolonging that process.

**Dr ROWAN:** To clarify that, is that really like an open access system: people not having to go on referral, but can go directly to the provider?

**Mr Beer:** Absolutely.

**Ms Sarah:** We have a strategy where we reverse market people back to the GPs and say you can refer to us directly. We have argued that with the PHN who funds us for stream 3 and stream 4. We just go, 'That's fine, we will go back and say this person is eligible. They have indicated they need psychological services. We will get a mental health care plan that way.' We all know about the Medicare system and those sorts of things. You can do it, but it is only if they present to you in the first place.

**Dr ROWAN:** But the PHN should have open access, that is what you are saying.

**Ms Sarah:** People are encouraged to go to their GP, get a referral, then the referral goes to the PHN, they do their intake and then it comes to us. Again, the journey is not friendly.

**Mr Beer:** But I am unwell today.

**Ms KING:** I feel tired just thinking about that. From the point of view of vulnerable people seeking care right now and in crisis, those substantial barriers are clearly an issue for getting people the care they need and preventing adverse outcomes. That was not what I was going to ask about. Sharon, you talked about the provision of offender services. Are you providing services to people while they are inside the system? Can you tell us a bit about that?

**Ms Sarah:** Do you want the one specifically for people with mental illness?

**Ms KING:** I would like to hear about both really.

**Ms Sarah:** One is funded by Queensland Corrective Services and that is pre and post transition support. We assist people to connect to housing and drug and alcohol treatment and all sorts of other services prior to release. We will support their parole application and help them when they are coming

closer to release. Then we assist them post release if they are on parole to then facilitate that access. The goal is to prevent them from going back inside and be successful on parole. For people with mental illness it is a lot more complex and obviously for complex clients the referrals only come from prison mental health. We do see them prior to coming out as well, but I guess they are targeted to provide that sort of specialist service to, again pre and post release. On each occasion those services are time limited.

**Ms KING:** Are you providing any alcohol and other drug services into prisons or are they provided at a prison level?

**Ms Sarah:** The QCS outsources that to providers and we have provided drug and alcohol treatment services in prison—individual and group programs. We are currently not doing that, but at least 30 per cent of our clients come from the Corrective Services system for drug and alcohol treatment, easily.

**Ms KING:** Do you have any awareness of what alcohol and other drug services are provided to prisoners who are on remand?

**Ms Sarah:** I doubt whether they would have any. Most services that are provided are to people who are in the main service system where they would be eligible for groups. We used to, and still do, in our CREST program, that is the QCS funded one, speak to people on remand, anybody that is in the prison system, about what services they could potentially access to help them deal with whatever they have got to deal with, but it is an information service. They can self-refer though.

**Mr MOLHOEK:** Thank you for being here today. Sharon, you touched on the issue of overheads earlier and you mentioned issues around risk management and red tape. The other week at the Brisbane hearings we heard the suggestion that the delivery of mental health services and support services was more cost effective outside of the public health system. I would be interested in your comments around the red tape and the impost that that has on your organisation in terms of service delivery and a proportion of costs.

**Ms Sarah:** From a Queensland Health perspective the funding is reasonable and in line with what we need to do, but in terms of the federal funding, no, it is significantly less and that is where the overheads are being eroded and reduced without an understanding of what we have to do. The federal funding reporting is monthly, whereas Queensland Health reporting is quarterly and sometimes even up to six months. It is far more reasonable and it has been negotiable. It is a bit like the NDIS, the reporting requirements and the ticking of this and checking of that and all that sort of thing. It is just incredibly onerous. I absolutely agree with accountability and good governance and clinical and program governance. That is my thing. But some of it is just for the sake of ticking boxes and giving data. I think that is where I get a little annoyed and say, 'I will give you what you need in terms of those numbers and the data, but tell me how that informs what we are doing in our communities. What are you doing with it?'

**Mr MOLHOEK:** What percentage of your total operating costs or budget would be spent on face-to-face practitioner time or client time versus administration and overheads?

**Ms Sarah:** It varies across programs. You ultimately do not get funded anything above more than 10 per cent of your budget. You are lucky if you get a bit more, but it is whittling down to eight per cent. My concern right now is just the work that we had to do around vaccination and COVID. Constantly managing that environment through this time has been incredibly difficult. Queensland Health were generous and gave us COVID money in the first year. We got nothing from the federal fund. The hospital and health services work within the hospital and health services. Queensland Health works the way that they work. That is not going to change. If we want to see innovation and things done differently we can only rely on the feds to do that. I am well aware of the missing middle and all those sorts of things, but I do not want to do things the same way. I want to see some innovation. The Productivity Commission and the *Wellbeing First* report talk about the need to look more around wellbeing. When you talk about somebody presenting to the GP, for example, we are not talking about our client group, the person with schizophrenia and those sorts of things, we are talking about you, me, something has gone wrong in our lives and we reach out for help and we need to have that help when we need it and getting rid of the shame and the stigma and those sorts of things.

Can I just add a couple of things: housing is critical, we all know that, but housing for our group is terrible. The unemployment situation for people with mental illness has not changed in I do not know how many years. The disability employment service model that is currently operating is just not fit for purpose. It is horrifying. Sorry, I had to get that out.

**Mrs McMAHON:** When we first got here we had a bit of a run-down of the demographics of the local Wide Bay region and there was a focus on an older population and a population that has a high disability rate. One thing that we have not really spoken about today is youth mental health services. We were advised that there was not any specialist youth bed capacity within the local health service here and that in many instances young people had to be sent out of the community in order to receive acute care. I was wondering if you could tell us for this area what options are there available for a young person or for a concerned parent when they have concerns that their child really is reaching out or needing assistance. What services do we have available in the local area here for youth mental health?

**Mr Beer:** We do have a headspace. Then we have the Child and Youth Mental Health Service at the HHS. Some of the federally funded programs may assist young people, but not those really complex ones, I suppose.

**Ms Sarah:** There are no beds. There is one homeless shelter for young people and the criteria for that is very limited.

**Mr Beer:** I think it has six beds.

**Ms Sarah:** Yes, but again there is not much collaboration or there is not much investment in that area to my knowledge.

**Mrs McMAHON:** Is there anything for the under 12s, noting that headspace starts at 12 years old?

**Mr Beer:** The Family Mental Health Support Service, which works with the whole of family, particularly those at risk of developing mental illness, and then CYMHS.

**Ms CAMM:** You mentioned that you have been removed from local planning and now it is just the HHS and the PHN in regional plans. When did that occur and why do you think that has occurred? Is that a structural issue or is that a personality issue? Communities change with the people that make them up. What has occurred over time for that to have changed from a more collaborative approach, if that was your experience in the past, to now? Is it about the people who have changed in those roles or is it about the structures that have changed over time?

**Ms Sarah:** The people have not changed in their roles at all. I think that is part of the problem. There was a needs analysis done around four or five years ago—let us say four; I will be generous. It was done very quickly. Then there was, I suppose, get-togethers of how the service system is going to work. The Mental Health AOD Branch are part of that triangle where they have worked on what they are going to do and how they are going to model things and what they are going to roll out which is where they recommissioned—well, they defunded the existing programs. We had a clubhouse, a psychosocial rehabilitation program.

**Ms CAMM:** Can you clarify that branch, is that under Queensland Health?

**Ms Sarah:** Yes, the Queensland Health Mental Health AOD Branch. They are responsible for funding community-based mental health services and drug and alcohol treatment services. That is government and then you have your HHS and then you have your PHN. They did their needs analysis, they had their book and what not and then the Queensland Health branch decided on how things will be funded into the future and had lots of modelling and that sort of thing and then recommissioned those services which is the community-based mental health service that Bridges delivers on an individual level and impacted delivery of the group programs. Our group programs were defunded which meant that we did not have that centre-based program anymore where we could train our workforce and so forth. Anyway, that is in the past.

I guess they sort of decided what they were going to do into the future and that was embedded into policies and plans and that sort of thing so they did not need to talk to us about it anymore. So those strategic meetings and discussions stopped. My biggest concern is that the PHN's brief is to do a regular needs analysis and that is just not done. I am not saying it is unique to our region, but it is certainly not unique to every region. It really needs to be done. We have tried to use the needs analysis to say, 'Hey, we want drug and alcohol services in the Gladstone community. We are constantly getting smashed and asked for drug and alcohol services and there is no continuity or consistency in funding.' We just had services out in Agnes Water for 12 months. 'Here is some money for 12 months. That is all you are going to get. Shut it down, go away again.' Twelve months funding is just ridiculous. It is stop and start.

**CHAIR:** I just want to follow up on that question from the member for Whitsunday. The Productivity Commission's recommendations or anticipation of a model is that effectively the HHS talks to the PHN, they work out a plan for an area and then they buy services from organisations like

Impact and Bridges, but from what I am hearing from you and from Steve you want input into that planning process rather than just being a provider of services once the decisions have been made; is that fair to say?

**Ms Sarah:** It is that as well as the longevity of it. Sometimes you do not know what that rationale is and that example of 'we will give you 12 months funding because we have a bit of leftover money for this region, but then you have to pull it out again', I keep saying to them causes reputational damage to our organisation, not to mention the community, how long it takes to set something up, start it and then out you go again. They are not blaming the HHS and the PHN, they are going, 'Oh, Bridges, one minute they are there, then they're not.' That is the continuity of funding. You have to have those guarantees to be able to deliver services to local communities.

**CHAIR:** We held our first community public hearing at a clubhouse in Brisbane and they were very much focused on group services. It seems to me the NDIS has driven things towards a one-on-one provider model rather than that sort of block funded group program that might provide an alternative. Has that been the experience here?

**Ms Sarah:** It is not funded well and if people do not turn up then you lose money, so, no. I am not saying let us go back to some of those things, I am saying we need to do things better. They still need to be within a recovery model, but one of the things that you do have with a group program is you have a training ground. I cannot take student placements or take people for work experience which impacts on the workforce shortages because we just do not have the capacity. We get funded, we have KPIs per FTE. We have to achieve those KPIs and if we are not achieving them then we are in trouble. So we cannot be going off and using our overhead money to be supervising people and things like that because there is not enough to do that. That is part of the issue. Whereas if you have other people, you have this place where you can learn and observe in a safe way, which is what we try and do, we can say, 'Yeah, you have a cert IV in drug and alcohol, you do not know much,' or 'You just got out of university, but come in and watch, observe and learn in a respectful way,' not, 'Here is a NDIS package, go do some therapy on somebody without supervision.' It is dangerous.

**CHAIR:** You talked about a wellbeing model of care, or a wellbeing model—I will get rid of the word 'care'. I am interested in that. I think every member of parliament would have that experience where you come across people in the community—and I know certainly from personal perspectives as you go through life you have relatives who go through divorces, business pressures, teenage kids, all the sorts of things that put pressure on people—and they are in no way, shape or form diagnosable with any sort of mental health issue that you can see but if they do not start to get some sort of help and advice, which often has been provided by family and friends, they are going down a path of perhaps some sort of mental illness developing. Can you step us through what a wellness model might look like?

**Ms Sarah:** I think when we talk about wellbeing we are talking about not just everyday Joe, we are talking about wellness and wellbeing. You can have a mental illness and have poor mental health or you can have a mental illness and be okay because your mental health is okay. They are two separate things. Everyone has mental health and when that is not going so well we are talking about our mental health and wellbeing and we need to do things that keep us well. So you think about the things that you already do. You go, 'Well, how do you keep mentally well?", and you go, 'Well, I cycle or I do this, I do that or I have a partner'—all those things. You have to unpack it. You do that for somebody whether they have a mental illness or they do not have a mental illness, because how have they survived in the meantime. Corey Keyes talks about flourishing and languishing. We need to help people flourish and not just be part of a service system where they languish and do not get well. That is what is happening in the NDIS where people go, 'I make money out of you being sick,' and that is criminal. We need wellbeing services where people can present and say, 'It's okay. We all need a bit of a top-up. We all need to do a bit more of that to keep us well.' It is no different to saying to people who have mental illness, 'Well, what do you like? I love playing with my dog. Do more of that,' or whatever. You know what I mean? That is about wellness and wellbeing and that is about flourishing as well.

**CHAIR:** I think that is a pretty good note to finish on. I want to thank you both for coming and presenting here. It has been a fascinating insight into not just the issues in your region but I think the issues around mental health and AOD services generally. On behalf of the committee, I would like to thank you both for presenting today, but I also want to ask you to please take those thanks back to the people who work in your services. It has been an incredibly difficult few years with COVID and I think all health professionals and people who work in health services have done an incredible job. On behalf of the Queensland parliament we would like to thank you and your staff.

**The committee adjourned at 3.55 pm.**