REPORT ON PROCEEDINGS BEFORE

PORTFOLIO COMMITTEE NO. 2 - HEALTH

INQUIRY INTO EQUITY, ACCESSIBILITY AND APPROPRIATE DELIVERY OF OUTPATIENT AND COMMUNITY MENTAL HEALTH CARE IN NEW SOUTH WALES

CORRECTED

At Function Room, Lismore Heights Sports, Recreation and Community Club (The Heights), Lismore Heights on Tuesday 13 February 2024

The Committee met at 12:15 pm

PRESENT

Dr Amanda Cohn (Chair)

The Hon. Susan Carter
Ms Sue Higginson
The Hon. Emily Suvaal

PRESENT VIA VIDEOCONFERENCE

The Hon. Mark Buttigieg
The Hon. Greg Donnelly

The CHAIR: Welcome to the fifth hearing of the Committee's inquiry into the equity, accessibility and appropriate delivery of outpatient and community mental health care in New South Wales. I acknowledge the Widjabul people of the Bundjalung nation, the traditional custodians of the lands on which we are meeting today. I pay my respects to Elders past and present and celebrate the diversity of Aboriginal peoples and their ongoing cultures and connections to the lands and waters of New South Wales. I also acknowledge and pay my respects to any Aboriginal and Torres Strait Islander peoples joining us today.

My name is Dr Amanda Cohn, and I am Chair of the Committee. I ask everyone in the room to please turn their mobile phones to silent. Parliamentary privilege applies to witnesses in relation to the evidence they give today. However, it does not apply to what witnesses say outside of the hearing. I urge witnesses to be careful about making comments to the media or to others after completing their evidence. In addition, the Legislative Council has adopted rules to provide procedural fairness for inquiry participants. I encourage Committee members and witnesses to be mindful of those procedures.

Ms KELLY BANISTER, Chief Executive Officer, Northern Rivers Women and Children's Services, affirmed and examined

Ms SONJA HABENICHT, Trauma Counsellor/Psychologist, Women's Outreach Trauma Health Service, Northern Rivers Women and Children's Service, affirmed and examined

The CHAIR: Thank you for being here today. Would you like to start by making a short opening statement?

SONJA HABENICHT: Yes. First of all, I would like to thank everyone for coming to the Northern Rivers and spending time in this beautiful region, because I think it does need a lot of attention, particularly post-flood. I would also like to start off saying that I'm the psychologist with the trauma outreach service, but I also would like to declare that I've been a case manager mental health clinician with the Casino and Kyogle Community Mental Health Services in the past and the public health under Lismore LHD. Considering this inquiry is about community mental health services, I'd like to maybe point out some risks and barriers first and move on to some suggestions.

First of all, coming from my personal experience and also still in the experience now in the professional capacity, I'm definitely noticing a distinct lack in service provision, unfortunately, and a very distinct lack of staffing across community mental health, particularly around in rural centres. I also know that the recruitment has definitely slowed down, particularly since COVID, flood and fires—all in a row—and I don't believe that has changed an awful lot since, because it's very difficult to recruit people to the region post-flood. So there's a high reliance on temporary workforces, unfortunately, which then poses a risk to continuity of care, particularly with trauma-affected clients.

Also, I'd like to point out that there is definitely a big splitting of services, unfortunately, with lots of different specialisations which are all really valuable, but, unfortunately, that does draw specialists or your core services out into lots of different departments which can then become, unfortunately, quite siloed, which can be confusing not only to clients but even to services, in terms of referral. Speaking as a psychologist, I know there are quite limited psychology positions in those largely held with a biomedical background, which, unfortunately, means that there is a big focus on biomedical services and medication and less on therapeutic intervention, which does undermine the recovery processes. I'd also like to move on by saying that something similar happens in the primary care service, with, again, GPs being difficult to access in the region and not being bulk-billed, which then pushes it out to the NDIS providers—

KELLY BANISTER: If people are eligible.

SONJA HABENICHT: —if people are eligible for any services. Moving on to being a women-and-children-specific service, I would like to highlight that there is a big lack of awareness of coercive control patterns and domestic violence presentations, and what that means for mental health is a huge overlap in symptoms and signs and how that affects people and a huge presentation of trauma has underlying relational traumatic incidents, which then presents as mental health which, unfortunately, will not respond awfully well to medication. Really, we are looking at better therapeutic interventions across the board. Similarly, with that siloing, alcohol and substance use will often be misdiagnosed as mental health and so on. Again, if departments could converge a bit better, misdiagnosis might be prevented.

I'd like to say that transport is very difficult to access here, which means that rural and regional participants are often unable to access services. And telehealth, while it definitely works for a lot of people, doesn't work for people who don't have broadband, who don't have funding to buy laptops or who don't know how to use those services. Also, if you do have telehealth services, you might not see the full presentation, unfortunately. For people with eating disorders, you cannot gauge that as well. What I'd like to see to improve those sorts of services would be really comprehensive induction, training and professional development across coercive control patterns and domestic violence awareness, and putting in some really specialised, specific assessment tools, making sure that it's not being misdiagnosed or left behind.

There are real risks to domestic violence presentations. In the service, we've got the MRG tool, which is a really specific decision-making tool. Something like this could, ideally, easily be developed for domestic violence also. I think that would be a wonderful approach. Similarly, trauma awareness and trauma-sensitive care should be very important and, ideally, merging some departments or, at least, improving the communication across those departments. I'd really like to see a fully integrated, trauma-sensitive, biopsychosocial model that very strongly incorporates alcohol and other substance use services and sees mental health presentations in a broader framework of domestic and family violence presentations.

KELLY BANISTER: If I could just add on to the end of that, also an understanding of the impact of gender across all of those areas that Sonja has talked about because it's different for different people, and different strategies are required. Gender does play a significant role in how that's shaped.

The CHAIR: Thank you so much for your evidence today and for all of the work that you do every day supporting such a trauma-impacted community. We are very grateful. I've got a couple of questions, and we'll also go to questions from the other Committee members. I was interested in your comments around that fragmentation of the social services and the mental health sector. We've heard evidence earlier in this inquiry from people with lived experience about some of the challenges navigating that system—that it can be quite overwhelming and complex and, sometimes, put people off accessing care altogether. In your recommendations, you talked about improved communication. I was hoping to explore that further. What would that practically look like if the State Government were to try to lead a better process?

SONJA HABENICHT: I know some of those systems are already incorporated in different States. I believe that in Queensland there is a more cohesive approach to domestic violence—for example, where you do have social workers, police and DCJ all sort of working alongside each other. I also know there is a similar service down in Victoria—I believe it's called The Orange Door—which provides services having all of those departments sitting together. Talking about Lismore, because that's where I'm from, I can see this working. I know they are very close geographically, but they don't necessarily share the same offices or the same meetings or things like that.

If those things could have really specific meeting times, or even have someone in there—say, a domestic violence specialist on the mental health team—so those departments start that communication, I think that would be a beautiful approach, or swapping around having three-monthly tenures across different departments. I'm talking from a really specific approach because I've come from the Casino-Kyogle team, which is a very tiny team, and it's gotten tinier over the years. Those offices could ideally be shared a bit more, but often you don't even know if someone's downstairs for that given day, or anything like that. So shared offices, even, could be a really—team meetings. Sorry, that's as much as I can come up with.

The CHAIR: I also want to ask Ms Banister to expand a bit further on her comment about needing more awareness of gender, or a gendered approach with mental health. As you would be aware, there's a number of reports now coming out about the flood response and, particularly, the incredible strength and role of women in that response but also the impact on more vulnerable women in that aftermath of disaster and a collective trauma like what's happened in the Northern Rivers. What should be done differently, from a mental health perspective, to care for women?

KELLY BANISTER: I think, again, it's about a more collaborative approach; it's about communication. It's about recognising the work that is done. You were referring to the floods, and a lot of women are still largely relied upon for the bulk of the caring responsibilities in communities, whether it's in response to the flood, whether it's mental health et cetera. There needs to be that understanding. They also tend to neglect their own mental health needs because they're concerned about the children, the parents, the partner and the rest of the community. I think there does need to be training around the different impacts of those circumstances, whether it's in the flood, and the different stereotyped roles that men and women tend to play or are recognised for and the way that's viewed.

It very much comes into play as well in terms of violence, domestic violence and particularly in the coercive control area. There needs to be an understanding about that. So really, in mental health, there does need to be deeper understanding and training around the impacts of gender and the implications of gender and gendered stereotypes. An area that we're working on at the moment to develop up some pathways is around, as one example, non-fatal strangulation, which is an issue that is happening more and more, but it's not being diagnosed. We're looking at strengthening pathways and connecting up organisations to help with the treatment further down the line, because often it's misdiagnosed or it's not diagnosed at all. It's a similar situation with mental health issues as well. Does that answer your question?

The CHAIR: Absolutely. You're obviously dealing with really serious issues, day to day, in your work. I'm interested in vicarious trauma and the way that it impacts service providers and health workers. Is there adequate support for the carers, or what do we need to be doing differently?

SONJA HABENICHT: When you're saying carers, do you mean service providers?

The CHAIR: Yes.

SONJA HABENICHT: Every organisation handles that quite differently. I know that within our organisation, we have certain debriefing and supervision practices in place, and wellbeing and employee assistance programs obviously are always very good. I know that headspace's Recovery to Resilience program has actually developed something very specific for that, even: training workplaces in developing debriefing strategies to really deal with that vicarious trauma. I don't know what public health does at this point, but from my experience working there I would definitely advocate for stronger supervision practices and making sure that they are accessible to all staff whether they are in a centre or not—similar with managerial and clinical oversight—and making sure that there is a regular check in around that because a huge chunk of the workforce in Lismore and Northern Rivers has been flood affected privately and they are going through these stressors for two years now alongside their work.

KELLY BANISTER: If I can just add to that, there is a lot of burnout—which I'm sure you're aware of—in terms of the workers. Given it's a regional area, we have such a limited workforce, which Sonja alluded to earlier in her presentation. We're all drawing from the same workforce to try to deliver services. Workers are working in, say, three different part-time in three different organisations. That's quite common. It's a huge problem. The point that Sonja made about it being different across all different organisations, whether it's government, whether it's community-based—I think having guidelines around best practice around the sorts of supports that work and that would be useful would be a really good thing.

I'm aware that Gender and Disaster Australia have been doing quite a bit of work in this space. They're also looking to develop guidelines and they, going back to what I said before about having a gendered approach, that's very much embedded in their work. They're doing quite a bit of work in this space in terms of being prepared for the next disaster, which is going to happen, and also trying to support areas that are currently significantly impacted. That really takes an in-depth approach but it also takes a broad approach in terms of across the State and across the country. We've been working with them to learn from our experiences in the Northern Rivers and how that might help people in other parts of New South Wales and the rest of the country.

Looking to the places that are doing research and that are developing guidelines around this—there's quite a bit of work going on at the moment so I think implementing some of them more broadly would be really useful because then we're all on the same page. I think it would really help in terms of the community, the support for the community and for the people that are members of the community that are servicing that same community.

The CHAIR: Thank you very much. I'd be really interested to have a look at some of that research or those reports if you're able to table it after the hearing.

KELLY BANISTER: Very happy to do that.

The Hon. SUSAN CARTER: Thank you both for being here. If I can continue the discussion in relation, in particular, to coercive control. Parliament has legislated with respect to coercive control. We expect those laws to come into force this year. I'm hoping that there's education with respect to the police. I'm wondering whether you've seen any other community education or education about those laws about who to contact and how they can be used best used to support women—whether that sort of education has been rolled out across the community services sector?

SONJA HABENICHT: The legal centres are at the forefront and I know we have been sent communication—unfortunately the name eludes me—which has a very broad and in-depth explanation of the new legislation. I know it's been rolled out across employers but I don't know how far it's gone community-wise though. I know that New South Wales has advertising on different platforms; however, I've seen that not too much and it wasn't too detailed from what I've seen. Being very specific about what coercive control looks like might be very helpful to individuals.

The Hon. SUSAN CARTER: Do you have any suggestions? We can pass all the laws we like but unless they're actually understood by the community and people understand what to do and where they can get support for these laws to be enforced—have you got any suggestions as to who should be educated or what that should look like or how specific it might need to be?

KELLY BANISTER: As I say, given our organisation I've been watching the legislation and the development of it, so knowledge that it's happening is there. But working within the women's sector, we still really don't have a clear idea about how it's going to be rolled out and implemented effectively. As you say, you can change the law but it doesn't necessarily change anything. I think the police are an obvious place where there needs to be a much broader understanding of what it looks like and the implications. Previously I worked in Tasmania and they had the "stay at home" legislation, which the police, for example, were educated around. But it ended up backfiring and both parties involved in the dispute were being arrested, which wasn't the intention of the legislation.

I think we need to be very careful about how it's implemented. The training needs to be not a five-minute thing for the person who is the DV liaison within the Police Force. It needs to be much broader than that, particularly when you think of the percentage of incidences that the police are dealing with on a daily basis that involve domestic and family violence. It's a huge proportion of the workload, is my understanding, so I don't feel that it's enough to relegate it to someone who is considered the person who looks after that. Often in other circumstances you find, because there is such a demand, if you like, that person or those two people who have had the proper training often aren't available at the time when that knowledge is required. It needs to be maintained and it needs to be regular, not one of those "Oh well, we've done that training." We all know what it's like—you do some training and you think, "Oh, yeah, that's great," and then time moves on and two weeks later you've forgotten because you've had a hundred cases come in front of you. I think that's important.

The Hon. SUSAN CARTER: One last question, if I may? I just wonder if you have any insights. I think we're all familiar with the situation where a domestic violence complaint is made and then, at the time it comes to court, for a variety of reasons it's withdrawn. Do you have any fears, with your experience of coercive control and given the nature of coercive control, that this will also be an issue around enforcement of coercive control? Are there steps that we can be taking, informed by your experience, to try to manage that?

SONJA HABENICHT: Yes. For one, it's seeing that it is a pattern approach; it's not coercive control or what happens with domestic violence. Incidences of these are often seen as single incidents and then you're talking assault versus assault, rather than when you're looking at coercive control as a pattern-based approach. It's highly manipulative, highly structured and ongoing. As for training, I believe different departments in Queensland have all done the Safe and Together training, which means that different departments can communicate much more effectively with each other because they've all got the same language. Applying the same approach to all different departments is probably a really smart idea because DCJ, Health and Police all overlap so much. Rather than seeing every single incident as an isolated thing, it is really having a very clear structure on how to approach it. Yes, I would advocate for that training. I've taken it myself and I believe it's very valuable.

The Hon. SUSAN CARTER: But to what extent do you think that training needs to be extended into the community sector, given they're the people who are most often encountering the women facing these situations?

SONJA HABENICHT: If we're talking about community mental health, ideally it would be community mental health workers. Private sectors and NGOs—that's always a great decision to make, ideally, but you'd probably want to look for not necessarily managers per se, but you're looking for people that are very interested; they're your forerunners. You get those people on board and, once they're on board, you can spread it a lot more easily. It's tricky.

KELLY BANISTER: But it is essential that it's not just one body within the public service.

The Hon. EMILY SUVAAL: Thank you to you both for appearing today. I just wondered if I might continue along this line of questioning and ask: In your view, do our State services provide care that is trauma informed?

SONJA HABENICHT: Do you mind repeating that?

The Hon. EMILY SUVAAL: Do our State services provide care that is trauma informed? And if not, what would that look like?

KELLY BANISTER: Could I ask you to clarify, when you say "State services" what are you including in that? Are you talking specifically about community mental health services?

The Hon. EMILY SUVAAL: Community mental health services, yes.

SONJA HABENICHT: I mean, it's a very contentious question. It is definitely incorporated into a lot of the frameworks and guidelines and so on. However, it does come into conflicts when you're looking at things like community treatment orders or how people are being recruited into the service or discharged, how families are being involved. So I think, at this current moment, some people are very, very good forerunners and they're doing everything they can. Unfortunately, that isn't the case for everyone though. And also, I think I'd like to take a step up from trauma-informed care to trauma-sensitive care. I think trauma-informed care is a very low bar, unfortunately, and I think it should definitely be raised a lot higher than that.

The Hon. EMILY SUVAAL: What improvements could be made, in your view, particularly in the context of crisis intervention, to make that more either trauma informed or trauma sensitive, as you say?

SONJA HABENICHT: Diagnostics, being one. Probably that's a really important angle as, at the moment, the way—again, if it's a biomedical model, you're very much looking at medication and medical interventions. So if you are stepping back a little bit from that and looking at it, I guess, similar to coercive control and domestic violence, it's a presentation—it's easy to diagnose someone based on a single incident, but if you're looking at a very long-term presentation you're probably going to be more likely to come up with something that doesn't fit neatly into your diagnostic categories. I guess the whole looking across a multiple systems approach will make it a lot more trauma informed, because you're not looking at a single time. If they're acutely unwell, you're looking at the presentation across a life span, within families. So involving multiple families, family members or whoever is involved in their care in general, in their intervention, I think, would be very beneficial and, yes, including multiple departments and maybe straying away a little bit from the medical-only perspective and really incorporating therapeutic interventions more genuinely into the services.

The Hon. EMILY SUVAAL: You mentioned earlier the MRG tool, is that correct?

SONJA HABENICHT: Yes.

The Hon. EMILY SUVAAL: Is that something that you're able to either expand on or provide on notice to us?

SONJA HABENICHT: Yes, so MRG is the Mandatory Reporting Guide at the moment. So if you have concerns around child safety, it's very easy to access online or through the existing systems and it will ask you a few questions. It's sort of like a flow chart, where you go "yes" or "no" and then it really gives you an idea to think about. What is the current acute risk? Is there an acute risk? What sorts of risk factors are there? And depending on how you respond to this tool, it spits out a certain message, "Okay, so this is an appropriate referral service", "This needs to be actioned straight away", and so on. So it gives you some very clear guidelines on how to respond to the specific scenario. I can see that being quite helpful for a domestic violence approach as well, because at the moment, front facing staff don't always know how to refer someone on when they're in a DV relationship, for example.

The Hon. EMILY SUVAAL: Thanks, that's very helpful. Ms Banister, did you have anything to add?

KELLY BANISTER: The thing that I was going to add that is a huge barrier, particularly in this region but in the rural areas, is the workforce shortage, because we can talk about all of these issues but if the workforce isn't there to deliver the service it's a problem. If you can't fill the appropriate shifts with the appropriately trained staff, you have a problem. And it's dreadful in this area—the shortages around mental health workforce.

Ms SUE HIGGINSON: Thank you for being here and thank you very much for the work you do for the women of our region. You said you service the Northern Rivers. Are you able to say where across our region there is perhaps a concentration of demand? I know it's across the whole region, but is there a place in particular in your service area where you're seeing heightened requirements for your services?

KELLY BANISTER: If I can just say, I did say we service the Northern Rivers, but the reality is we're a relatively small organisation. Our footprint tends not to go into the southern area—the Grafton area. They're often serviced up from Coffs Harbour, because we just don't have the capacity to do that. In recent times it has really been those areas that were worst flood-impacted. There's a huge demand.

SONJA HABENICHT: Like Kelly said, there's definitely a big demand and it's quite easy to fall into certain areas quite easily. Some areas are much easier to access as well, as a service. I'm speaking from an outreach perspective. In collaboration with other services, when there are already services, it is quite easy to go and just add another program to something that's already present. However, the further west you go, the sparser it gets. I would definitely say that the closer to the coast, usually, the more accessible things are, even if there are a lot of public transport issues and so on. I would probably say the further west you go, people aren't even requesting services because it's not even—

KELLY BANISTER: On their radar.

SONJA HABENICHT: They don't even think it's going to happen.

KELLY BANISTER: It's very hidden, and that's a difficulty with delivering services. You've got this compound of issues, including workforce shortages, no public transport, damaged roads et cetera in the aftermath of the flood, and no services, particularly in the western areas. So it's very hard to actually access the women when there's controlling behaviour going on. How do we even identify that they're there? They don't know about us. They don't have a way of accessing us. That's very challenging. Then you've also got areas like the multiple-occupancy properties. That is another area where I think there are a lot of hidden problems, and access out of the area and into services is very difficult and very challenging for them.

Ms SUE HIGGINSON: I have a similar question in terms of what you're noticing. I'm specifically interested post-flood because that's the concentration. Is there a particular age of women or is it across the board? Where are you seeing the greatest need?

SONJA HABENICHT: I would say that I've definitely noticed elderly women and older women becoming more susceptible to homelessness and not being able to access services. That's something I know we've engaged with fairly well in recent times. Younger women are very difficult to engage at times as well, especially with the rapid changes in housing. Families tend to be the ones that relocate the most frequently, from what I've noticed. Younger women are displaced and then staying with friends or family, again not feeling confident in their help-seeking.

KELLY BANISTER: I have strong concerns for young women in the community because there isn't a lot. They've been doing it very tough in the last couple of years, and I'm sure my colleagues that are going to be following us from Human Nature will be able to talk about this. There's very little service for them. Their schooling has been interrupted because of the floods. They may not only have been displaced at home, but they've no longer had their familiar school to go to. If they're lucky they've been relocated, maybe at the university et cetera. But, I think, with young people in that space that's going to be an area where there's going to be a big growth in mental ill health.

Ms SUE HIGGINSON: I noted in your opening you were talking about the knowledge that there are going to be more disasters, more increasing, more frequent. Is that something you are seeing presented from young women, that knowledge and fear, and as we refer to it more commonly, the climate anxiety? Is that something that is presenting to you?

SONJA HABENICHT: Definitely. It is not necessarily the primary presentation, but it is sort of an underlying change in attitude. I have also seen the flipside. A lot of young people know that it's going to happen anyway. It is just something that they're really proactive about and engage with really readily. You can see both ends. It's just their daily life and I think especially after COVID there have been so many changes in such a short period of time. People just take it in their stride and become community leaders that way, and other people feel more isolated, because during COVID they couldn't see their friends and now after the floods a lot of people have moved. It's just that new—it's almost like a permanent isolation. The biggest problem I've seen is people not just being able to not access services, but also just not being able to access the community in all its levels.

Ms SUE HIGGINSON: I know we are running out of time but I have an unrelated question. When you talked about the prevalence of coercive and domestic violence amongst the people you are servicing, do you have a clear relationship with police and when you would refer something because it's criminal? Or do you stay away from that kind of intervention and focus on the healing, the health and the safety of women?

KELLY BANISTER: We are not a crisis service, although we see women in crisis. We refer on to the appropriate service. The thing that makes it very challenging for us sometimes is the limited availability of the appropriate service, and then the response. Anecdotally there are stories that we could share, but the response from some of the mainstream services, if it's a specialist women's crisis service, they tend to know what they're doing, as you would expect. But when it comes to the more mainstream services, it can be a little bit hit and miss and you can be concerned that the person is going to be more traumatised by that intervention than not.

SONJA HABENICHT: I definitely have seen a change in funding of staff being across different departments. There's a bit of handball sometimes—we've got availabilities, they've got availabilities, cross referring, people moving from public to NGO, to private. There's a lot of that sort of hand pulling of clients across the region, which is wonderful when specialists or professionals know each other, but it can undermine a lot of care because it's so fractured. What we know about trauma is it's all about predictability, consistency, safety. I guess improving long-term care, at the moment with the current existing community mental health services they are definitely trying to cut them quite short, but what we know about trauma is we want to really provide safety long term. If that's something we could put in place that would be lovely.

KELLY BANISTER: Yes, I think that really needs to be looked at—the mandatory compressed time frame and something done about that—so there is the capacity for more longer term.

The CHAIR: Thank you again for your evidence today. The secretariat will be in touch with you if there are any questions on notice. For the awareness of people who are in the gallery and anyone watching online, we did have a last minute change to the hearing schedule today. We will take a pause now. The next session will start at 1.30 p.m.

(The witnesses withdrew.)

(Luncheon adjournment)

Mr ANDY HAMILTON, Therapeutic Lead and Founder, Human Nature, affirmed and examined

Ms JENNIFER PARKE, Head of Operations, Human Nature, affirmed and examined

The CHAIR: I welcome and thank our next witnesses for being here. Would you like to start by making a short opening statement?

JENNIFER PARKE: I will. First of all, I would just like to start by thanking you for this hearing taking place in the Widjabul Wia-bal lands of the Bundjalung nation. Part of our submission to the inquiry was requesting a regional inquiry because there are very specific needs in terms of access to community mental health services. This is second-best, and we're very grateful. What it means is that a small not-for-profit like ours can actually attend face to face, so we're grateful for that opportunity.

By way of introduction, I have worked for—I do hate to say it—more than 30 years with some of our most vulnerable and disadvantaged young people. That has involved working in youth homelessness and child protection, juvenile justice and survivors of sexual violence. Most of that—well, a large part of that time has been in senior management, so both in Federal and State government services and across the not-for-profit sector. What has led me to where I am today is, unfortunately, most of those systems actually do not serve well the young people they exist to serve. I have had increasing frustration about witnessing and also being part of those systems that are actually not providing what it is that young people are actually quite clearly telling us that they need.

Human Nature Adventure Therapy—we are a northern New South Wales-based not-for-profit. We exist to change the life trajectories of young people, 14- to 18-year-olds, who are experiencing really significant mental distress. We know that, through many years of firsthand experience, with the right support, young people can overcome extraordinary adversity and thrive. We know that therapy works, but there's a great deal of evidence that will tell you that adolescents are the least likely group to seek help or to access professional care for mental health problems, particularly those who are most vulnerable or at risk of poor outcomes.

At Human Nature, we occupy that enormous empty space between headspace and hospital, called the "missing middle", which I'm sure you've heard plenty about in this inquiry. It's a pretty lonely, large empty space that we occupy there. What we see is that medicalised model of the community adolescent mental health system means that these really highly evolved survival skills that young people have developed, particularly young people with complex trauma, makes accessing that office-based support impossibly challenging. The ability of a practitioner to develop therapeutic alliance with a client is really highly predictive of outcome. It's also really highly predictive of retention in therapy. To strip that back, your relationship with your therapist is key to actually having any benefit from therapy at all or actually bothering to—being able to turn up for your second or subsequent appointments.

Human Nature has designed services that explicitly respond to the needs of regional young people. Those are young people struggling with mental health, behavioural difficulties and social exclusion. What we have done is we have combined highly individualised, clinically proven, evidence-based mentoring and therapy, delivered through an assertive outreach model, with fun and engaging activities in nature. The "fun and engaging" isn't just because we think it's nice for young people to be outdoors. It's actually, again, absolutely based in evidence, and the evidence says that therapy delivered outdoors and moving is actually highly relevant for adolescents and is a really powerful engagement and relationship-building tool in itself.

We've got a multidisciplinary team of qualified mental health professionals and highly skilled mentors and we work wherever young people feel safe and motivated to engage. That might be in their homes or their schools, in a public space or in outdoor places. It's also very often in cars, actually: driving a young person to a headland, sitting on a headland and all of the metaphors of the ocean that you can find to articulate your mental health are all laid out there in that process. We deliver a mix of one-on-one sessions, group activities and multi-day therapeutic expeditions and camps. As I was saying, there is a growing evidence base showing that outdoor therapeutic-based interventions are highly engaging and motivating and really appropriate for the adolescent stage of development.

There is recently published research on the quality of treatment for depression and anxiety disorders in Australia. That has defined "minimally adequate" treatment for psychological therapy as six or more sessions. That is for adults, but using that definition—because I haven't been able to find research for adolescents—only 28 per cent of headspace clients received minimally adequate treatment for depression and anxiety. Almost half—45 per cent of headspace clients—received as few as one or two sessions, which was nowhere near the minimum.

We supported 130 young people in 2022-23. Some 95 per cent of those young people engaged in at least 10 sessions, in contrast with the statistics I was just providing for headspace. Between 25 and 40 per cent of those young people are First Nations young people. That's been without employing any Aboriginal staff until very recently. We now have two Aboriginal mentors. What we've found is that without Aboriginal staff, young people still felt safe to choose a voluntary youth mental health service that wasn't an Aboriginal controlled service and didn't have Aboriginal staff.

We did a very important piece of research employing an Aboriginal consultant to interview all of those Aboriginal young people and ask them what made them feel safe coming to us, what we did well and, of course, what we could do better. They spoke really powerfully about it being the quality of the relationship, that "My psychologist got to know me, got to care about me. I actually got to know something about them, as well." There was no prescribed limit to the number of sessions. They talked about being on country, being outdoors and feeling safe—which, again, goes to your trauma-informed question earlier. Of course, they gave us really important feedback about what we weren't doing so well. That's provided a really beautiful cultural safety framework for us going forward to ensure that we actually do centre their voices and their feedback to us.

In amongst all that, the biggest challenge for us is sustainability. We are currently operating without any government funding. We are entirely philanthropically funded yet we support some of the region's most vulnerable young people. We implore the Committee to consider these invisible young people—they're those young people that are least likely to walk through the door of funded services such as headspace yet they're the most likely to be requiring more costly downstream interventions and facing tragic consequences—and to prioritise the resourcing of specialist services such as ours. Thank you.

The CHAIR: Thank you both very much for taking the time to share your expertise and your experience with us today, but also for all of the wonderful work that you're doing. It's really valuable for us to hear about it today.

JENNIFER PARKE: Thank you. I do describe it as a labour of love.

The CHAIR: I have a couple of questions, and then we'll go to questions from other Committee members. In describing your service delivery model you used the term "assertive outreach". We heard that term earlier in this inquiry, but I was hoping you could just explain in detail what that means day to day in terms of how you interact with your patients or clients.

JENNIFER PARKE: Absolutely. The outreach model is a really critical part of our service—and there is less and less of it being done. Most services consider it too risky, too difficult to manage and too costly. What outreach means, as I said, is we go to wherever we can maximise the capacity of a young person to engage with a service. That will vary over time. The first visit is almost always at their home, and that's also an opportunity for us to start a relationship with their parent, which is obviously critical. It provides us with really valuable insight into what's going on in their lives, what that home environment looks like, what the relationship with a parent or carer is like but also meeting them on their turf at a time and a place and a location that, as I said, is about being trauma-informed and creating that safety right from the beginning.

And then the outreach kind of continues from there. For some young people, that also involves—a session might involve op-shopping. We're called adventure therapy but for some young people playing chess in their backyard with their psychologist is a big adventure, and we'll be doing that as well. So it's a really key part of our service; it's a really expensive part of our service. It requires vehicles, it requires a whole suite of lone worker safety policies and procedures and frameworks, all of which we have in place. But it's the missing ingredient. I have to say services will often sit in their offices and complain about young people who won't engage, and my response to that always is, "They can't engage. It's not their job to engage. It's our job to engage them."

The CHAIR: Just a follow-up question on that, in some of the evidence we received last year, the issue of lone worker safety was described to the Committee as a barrier to services engaging in, for example, home visits. Could you just let us know in a bit more detail what protocols you've got in place and if there have been any safety incidents for your staff?

JENNIFER PARKE: Yes, for sure. It is, again, something we've done a lot of work on. We employed a contractor to really research the issue for us but also to interview all of the staff one-on-one anonymously so that each of them were able to give feedback about the aspects of the job where they did feel safe and where they didn't and what improvements we needed to make, and also looking at the best practice evidence research around the world. There are a whole lot of lone workers from vets and midwives to, unfortunately less and less frequently, youth workers.

So we've introduced things, like all of the cars have satellite tracking. All of the staff have a personal safety duress app on their phones, which means we can track their location but it also means with the shake of a phone, they can make an immediate duress alarm to a 24/7 service. We have a whole range of training for staff in protective behaviours, dynamic risk assessments. We carry out that risk assessment of that first location, that first home, and it's a really comprehensive risk assessment. What we've learnt is that on the whole we can manage and mitigate risks. Once we identify them and we're front and centre about, "This is a potentially risky way of working," the conversation shouldn't stop there. There actually are a whole range of practices that can be put in place, and it's an ongoing constant refreshing with staff. Sorry, there was a second part to your question.

The CHAIR: Have there been any incidents?

JENNIFER PARKE: We have incidents because we're working with young people who have complex trauma, and as I've said they've developed really heightened survival skills to get through life. I would say the incidences are of a lower nature and are not as frequent as the kind of common perception would be of a service like ours, and certainly have never been raised as an issue by our insurance, which is a very good litmus test.

The CHAIR: My last question is: In the feedback you get from the young people that you engage, what impact does it have on them to have engaged with a service that isn't catered for young people?

ANDY HAMILTON: Perhaps if I can start on that one. I think one of the key points is that, as Jen mentioned, many of the young people we work with have actually either found themselves unable or flat out refused to engage with conventional therapy in a clinical setting, and so for them that may have been based on past experience of a school counsellor or another counsellor where they felt trust was betrayed or they just were uncomfortable in that environment. It may be because of stigma. It may be because of their personal circumstances and anxieties. But I often like to say that what we do isn't rocket science. Youth workers in particular, there's a whole profession there that's been doing engagement of so-called "disengaged youth" really well for a long time.

They don't necessarily have the clinical skills and the training to work in a trauma-informed way. Psychologists and social workers, who we predominantly employ, do. But they often don't get out of the clinical setting, and for the most part don't. For me, there's just been such a massive gap in service. We started and we built Human Nature from witnessing those young people falling through the gaps over many years. Often the young people who are most vulnerable and disadvantaged, and most likely to end up in tragic and dire circumstances, are the least likely to engage in those conventional approaches.

The feedback we get from young people is that they feel seen, they feel heard and they feel met. They're often as reluctant as ever to engage initially, and our team work really hard before they even meet with the young person to talk to family, to talk to people at school, to talk to the referrers and to have a really good sense of who they are and where they're at and what's going to be safe for them—where they're going to feel most safe, who with. It might be that there's a welfare worker at the school that they connect really well with, so we'll go and meet with them in the welfare room at school as a first initial meeting, because they don't feel comfortable at home. So whatever it takes, basically, and I think that's really felt by our young people.

Prior to the existence of Human Nature Adventure Therapy, one of our core programs, Recre8, has been running for over 15 years in the region. We've had probably around 300 young people go through that by now. We run an alumni-type program, a leadership and empowerment program called the Elev8 program, where young people can remain engaged and mentor and provide peer supervision and support for other young people. We're closely connected with them and, yes, there's a lot of appreciation for that kind of support.

The Hon. EMILY SUVAAL: Thanks to you both for appearing today. I wanted to start by asking if you could tell us if there is a usual context in which people seek support from your service, and what that is.

ANDY HAMILTON: As Jen mentioned, we are almost entirely philanthropically funded and grants based. As I mentioned, the drive for starting this organisation was for young people falling through the gaps. We've been very deliberate about targeting our referral sources to those who are most likely to be working and to be able to identify those young people, and then we hone them down very carefully. Because we tend to do what it takes to work with them—and that can sometimes be a considerable amount of time, and we're a relatively small service still—we want to make sure that the young people we are supporting are those most likely to need it.

Those referrals will come from—many from schools, school principals and heads of welfare and school counsellors, who can often identify a young person for whom they're pretty certain it's not going to end well. They're not there yet—we're really trying to work in the prevention space—but they can see they're heading for a bad place, and they've tried to get them to see the school counsellor; that's not happening. They've tried to get them to a boys' group or a girls' group; that may or may not have been successful. They're not engaging with school, they're not going well and so they'll identify them, specifically. Parents increasingly are contacting us as we become more well known.

Again, we have a pretty strong filtration process because there is a limited number of young people we can work with. The need is massive, and I guess that's something I really want to emphasise to you. I know you know that, but the need is massive, and it's massive in this region, specifically. We speak about the floods but, nationally, there's been a range of things, including COVID. For young people in this region, the 2017 floods were huge. Through that period of development, the 2017 floods, the bushfires, the COVID lockdowns and then our most recent floods mean that their key stage of development has been severely affected by traumatic events. There's just such a great need for that level of service that is going to find and support those young people who are most likely to end up in bad places.

The Hon. EMILY SUVAAL: Has the need for your services grown over time, or is it a result of more people becoming aware of your services? Is it one or the other, or both?

JENNIFER PARKE: I think it's both.

ANDY HAMILTON: Both, yes.

JENNIFER PARKE: I mean, Patrick McGorry talks a lot about—the mental health of Australian youth is really declining and it's actually a fairly global trend. There's lots of research around what that might be. Social media and climate change would be right up there, so I would say it's both of those things—growing demand and growing awareness.

The Hon. EMILY SUVAAL: With someone that uses your services, is it usual for them to require that for a period? Are they needing to come back? What's the usual, if there is one, entry and then the amount of time they might spend with you receiving care?

ANDY HAMILTON: There's certainly an average and we deliberately don't have a set, fixed amount of time because, if we can turn them around quicker, we'd like to move them on quicker. We really are trying to move them on. One of the things we'd like to be able to do is to season young people for conventional therapeutic approaches because that's mostly what's available. We do want them to get to a place where they could go and get support from a headspace service and remain engaged, or a private psychologist, because we can't support everybody. Do you want to add to that?

JENNIFER PARKE: This may come up later. We have a close working relationship with the community adolescent mental health system because, again, when it's a parent referring to us, often the young person has presented to hospital, there might have been a suicide attempt or a self-harm incident, they've come into that very medicalised model and the young person has been unable to engage with it and so the parents are cast adrift and fairly desperate. What we've introduced fairly recently is a very intensive intake assessment process, primarily so that we have language to push back on that system and to say that, actually, these young people we've assessed as too critical of need—their level of acuity is too serious for what we can hold as a small non-crisis not-for-profit service. But the other challenge for us is, within that nine-month average of how long we work with young people, they develop such a strong relationship with us and our way of working that it's actually very difficult for them to then engage with a service structure that has a kind of statutory response to their level of need.

The Hon. EMILY SUVAAL: Of course, you're dealing with them at a time when they'd be transitioning from the child and adolescent system into the adult system of care, which are also two very different systems of care. So you say approximately an average of nine months?

JENNIFER PARKE: Yes.

The Hon. EMILY SUVAAL: I'm not going to use the term "discharge", but is it a sort of tapering off process but with an open door?

JENNIFER PARKE: Very much.

The Hon. EMILY SUVAAL: What's worked? Is there anything that would make it more effective?

ANDY HAMILTON: A part of our exiting strategy is to, if that young person is requiring ongoing support, provide warm referrals and take the time for them to properly engage with other support services. But also we will remain, have an open door policy to them so that if they—most of the time they live tumultuous lives. Things happen. They may be travelling quite well and then regress somewhat. So they can come back and see someone they already know and reconnect with us there. The Elev8 program I mentioned earlier provides an opportunity for a step down type service, where they can engage in some day program type activities—so adventurous activities that we conduct with peers and with our staff so there is a way of them remaining connected over that time.

Ms SUE HIGGINSON: Thank you so much for being here and for the incredible work you're doing for our young people. If you could get anything from government, what would it be? Just reflecting on the fact that you said you've already done some of this really hard and heavy lifting in terms of those protocols and working alone, if you could have anything from government, what would it be?

JENNIFER PARKE: Multi-year funding. It's the multi-year that's absolutely the trick. We received, for us, significant funding post-floods, but they were two one-year grants. We increased our service delivery by 191 per cent, but then we were on a funding cliff at the end of that first year. That multi-year funding would be key for us. I honestly believe that every regional centre in Australia would benefit from a Human Nature model. We've been doing a lot of work in terms of getting those organisational infrastructure pieces in place so that we can be in a position for Clarence or somewhere down in rural Victoria—I don't know even know that area; Gippsland, I don't know; but an area where they can see they've got a growing population of young people with deteriorating mental health who cannot access these medicalised, short-term models—to be able to say, "We want a Human Nature," and for us to be able to say, "Well, this is what it looks like and this is our kind of scaling up and out process," which is what we're really trying to focus on. But, again, when we have to expend so much energy funding us to just open the doors, it gets in the way of the service delivery.

Ms SUE HIGGINSON: And so—sorry, go on, Andy. You were going to say something.

ANDY HAMILTON: I think I'd just say, more philosophically, I guess, that a recognition of this gap—I feel like it's not recognised enough, and the degree of pressure that that puts on the acute State-based services. They are simply not able to cope, so there's often a revolving door that goes on with people with self-harm and suicide attempts: going into those services and then being pushed back out because they just don't have the capacity to support them. More upstream support from services like ours can have massive impact on the stress and pressure of those primary services.

Also, more broadly, the intergenerational nature of what we're dealing with—I think at some point we need to start really focusing on investment around interrupting those cycles of intergenerational trauma and disadvantage. My feeling is that this is a really key place to do that, where it can be quite impactful. I started my career 25 years—over 25 years I've been working in the mental health and criminal justice and drug and alcohol sector. The reason I moved into working with adolescents was seeing adults in that sector who had absolutely had those early signs within adolescence of things that were going wrong, and then the compounding trauma that happened since then from addiction, from behavioural stuff, from institutionalisation has made their situation so much worse. So there's a need to address these things at adolescence.

And then working with adolescents and seeing how, as I said before, those most vulnerable are least likely to engage with what is on offer in terms of conventional clinical approaches means that they're often invisible. They're not seen by the system. Particularly in this region, where schools are in chaos post-floods, and many young people just haven't returned to school and aren't engaging with those services and aren't being seen, but they're absolutely there and they're absolutely going to continue to have impacts as they become young adults and adults in both our systems and our society.

Ms SUE HIGGINSON: In terms of the substantive nature of the programs, human nature and the nature component—you refer to meeting young people in nature. Is nature itself a component—the relationship with nature as opposed to just sort of being in nature and having nature there as part of it—in terms of the human interaction with it, the way we manage it and the politicisation of the environment? Or is it not?

ANDY HAMILTON: I would say two things about that. One is that the evidence is increasingly clear of the positive impacts on wellbeing of exposure to nature, immersion in nature and connection with nature. That is what I would say is a positive side effect of our work, as is physical exercise, fresh air, sun, nutrition, connection to others—all these things are so good for mental health and have a really strong evidence base. At the same time, it was brought up earlier about what is commonly referred to as climate anxiety. In my experience, almost all young people are in some state of that and seriously concerned about their future. Those young people who are already vulnerable, who may have experienced complex trauma and disadvantage, are even more impacted by that. Our relationship with nature can be an antidote to that and, particularly, positive climate action as well.

Ms SUE HIGGINSON: In terms of the geography—I may have missed this, and I apologise if I did—of where you are, where are you finding the most presentation across the Northern Rivers? Is that something that you can share?

JENNIFER PARKE: Sure. We are based in Ballina and we work with young people across the Tweed local government area—the Tweed, Byron, Ballina local government area. Because of the size of our service and the recent limitations to funding—with the flood funding ending, we've had to restrict our services. So we can now only provide service to Lismore, not to Nimbin, and to Evans Head, not to Coraki. I would be saying that they are two areas with high need. As the previous people have talked about, the further west you get—Kyogle and Casino. I would say, even within that strip that we cover—and it is a coastal strip—there are still very high levels of need. Within that area we're covering almost all of the pod villages, and we have young people who are living in those villages, and all of the uncertainty that that's created. I mean, I would say, yes, Lismore and Mullumbimby is where we're seeing, really, that kind of heightened, persistent trauma symptoms as a result of the flood in particular. But in terms of young people's general health, I would be saying that across the region young people are really struggling.

The CHAIR: I can see that you've got a pile of documents next to you. Is that something that you'd like to table?

ANDY HAMILTON: That's our recent impact report, just recently published, so, yes, if we could table that.

The CHAIR: Thank you very much. Thank you so much, again, for all the work that you're doing and for sharing your experiences with us today. The secretariat will be in touch if there are any questions on notice.

(The witnesses withdrew.)

Ms FAY JACKSON, Former Deputy Commissioner, Mental Health Commission of NSW and General Manager, Inclusion, Flourish Australia, affirmed and examined

The CHAIR: I welcome our next witness. Thank you so much, Ms Jackson, for taking the time to share your evidence with us today.

FAY JACKSON: Please, call me Fay. I am the inaugural Deputy Commissioner with the New South Wales Mental Health Commission. However, I am no longer a deputy commissioner. I am currently in the position of general manager of inclusion with a very large not-for-profit, specialist mental health service, that is in many areas of New South Wales, Queensland, South Australia and Victoria. However, funding hasn't been available for us to move into this area. I live here, though, and am a committed member of this community. Community is often all we've got here. I'd like to acknowledge the traditional custodians of this land, this beautiful nation that we're on, Bundjalung nation, and pay my respects to Elders past, present and emerging. I promise to walk gently on this land while I have the privilege to live here and raise my children and grandchildren here.

The CHAIR: Would you like to make an opening statement?

FAY JACKSON: I suppose my opening statement would be, probably, that the way I will present and what I'll present to you may be very different to anything else that you hear. I am very passionate—as everybody is that works in mental health, or should be—but I will be speaking to you more from a lived experience perspective of being a consumer. I don't use that word, though, anymore—gloriously—because I've managed to break those ties. I am a person with lived experience of severe mental health issues. I've been incarcerated by mental health services, treated against my will. I'm also a carer, though, of children and grandchildren who have mental health issues and I've worked as an advocate for the past 27 years, in the public system, then in the commission and now in the not-for-profit sector.

I have these documents that I'd like to table—or give to you now—that you might want to look on. There's a lot of information there that you won't want to go through now, but just to say that Northern Rivers is a hothouse example of what all regional and rural areas are experiencing across New South Wales—well, across Australia. Although we would be considered rural or regional, because of public transport and the lack of services here, we're really remote, in my opinion. There's such a huge difference between what's available in the city and what's available in areas such as where we live here.

However, having said that, what's available in the city, according to the productivity review, the royal commissions et cetera, are broken services anyway. Those are the actual words that are being used: "broken services". Advocates have been saying that for 2½ decades; however, it seems as though it's falling on deaf ears. It can no longer fall on deaf ears. We now here have the highest rate of suicide—I'm sure you've already heard this today—in Australia. However, I really believe that we are just an example of what's to come for other areas. We can't continue trying to get services that aren't there, or services that don't fit the needs of anybody. And they are not only not fitting the needs of people who need the services, they're not fitting the needs of staff either. The staff are getting exhausted and mental health issues because of the models that they're working in.

As a deputy commissioner I had the great pleasure of going to many services across New South Wales, Australia and also internationally. In New South Wales all of the public services are operating under the same policies, the same protocols, yet the culture within those services is very different. The cultures in services that value the voice of lived experience and peer work are far more healing for all people who access those services. I was the lead writer of a chapter—I was invited to write a chapter for the Australian *Handbook of Rural, Remote and very Remote Mental Health*. I wrote that with a number of people. One of them was a director of nursing at Goulburn Base Hospital. I asked her to review all of their episodes of seclusion and restraint. She looked back over an 18-month period and what she found was there were no episodes of seclusion and restraint when a very well-trained, very experienced peer worker was on duty. None.

People with lived experience supporting people with lived experience—we are hope personified in front of them. We talk with each other. We have a way of connecting that is almost immediate. We know peer work works. We look at AA, NA, Nursing Mothers Association, gardening clubs, whatever. Peer work works. However, it seems as though we have to keep on saying and producing more and more and more and more research showing the same things about the quality and value of peer work to people with lived experience of mental health issues. I really beseech you, please, really open your hearts, open your minds and know, because we know that the services are broken that we have to produce services a different way.

Flourish Australia, who I work for, has a peer-operated service in Hervey Bay in Queensland. That peer-operated service has not had a single suicide in the whole time that it has been operating. Wide Bay public mental health didn't want to work with our peer workers first of all. They were frightened of them: "Everybody that's crazy is dangerous". Ridiculous kind of attitude, with no factual background in saying that kind of thing. It took us a while to get them to work with our peer workers. After only about a year, I received a phone call from the head psychiatrist there—the intake officer—saying that their whole service had changed because of the way our peer work service was supporting the public system.

The doctor told me that what they would do was a person would come into A&E. Of course, A&E isn't the place for people who are in psychological distress. There needs to be a standalone, peer-run service that people can go to on the hospital grounds or, preferably, in the community, first of all, so that they don't even get to the point of needing to go to hospital grounds for anything. They go there and then are diverted away from hospital into these community, peer-operated services. He was saying that he rings our staff. Our staff speak to the person on the phone and ask their permission to come and see them. They then drive, whatever time of day or night. They go and they meet with the person. There's a magic that happens between people who have lived experience. There's a shorthand and a spiritual connection between people almost immediately.

Our peer workers start with saying, "I'm a peer worker." The people ask what that means. They explain what a peer worker is—that is, "We purposefully use our lived experience to connect with you and support you and build hope that you will be okay and that your life can change. There is a better life ahead for you." They purposefully give small amounts of their story to connect with the people so that the people know that the person that they're talking to hears and understands them without judgement or any kind of persecution.

The person then goes with the people back to our service. Unfortunately, like so many services that have proven that what they do is wonderful, we lost funding for the respite house that we had. We were able to take people into the respite house and have supports for them there 24/7. Now people are just coming to our day service and our staff go out to their homes and support them in their homes. The psychiatrist has told me that they've gone out to our service and seen how the people supported there and are seeing that people, within a very short time, are getting jobs, going to TAFE and going to university. They're being citizens. They are not being "the mentally ill". They're being citizens.

In rural and regional areas, in particular, everybody needs to pull their weight. I grew up on a farm in a rural area—not this area. But you know when you're living in a rural area that everybody must pull their weight. We saw that during the floods. If it weren't for each of us as a community member supporting our neighbours, and supporting the people close by, hundreds more people would have died. People who were responding to their voices that they hear were working beside people who are school teachers, nurses and ex-army, digging, trying to get people safe, trying to get people out of the water, and trying to save people's lives and clear up the mess afterwards.

If people with lived experience can do that in that Armageddon kind of situation, then what more can we do if we are given the chance? In the documents that I have given you, you will see that there is lots of proof, data and research showing that peer work works. Peer-operated services in the community are a way for people to be able to go there without fear. You have just heard that many of the kids and young people won't engage with the clinical public services. That's not just kids; that's people across all ages. Survivors of mental health services—we talk about us being survivors not of the mental illness but of the services, of the systems—

Ms SUE HIGGINSON: Of the system.

FAY JACKSON: —because we experience intragenic harm through the services. We go into a service—we may be coping, we may be scraping through, we may be managing to keep our jobs and pay our mortgage and do all that, but we have experienced trauma, very often in our childhood, like these poor kids around here have. They will have terrible mental health in the future if we don't act now—now! But most people, as you will see there—52 per cent of women who have come out of domestic violence get a diagnosis of mental health issues after they have experienced domestic violence. That's just one example of trauma. Around 87 per cent of people who have been sexually abused as children, as I was, have a diagnosis.

Diagnoses, in the long run, don't help. What diagnoses do is let the community and the perpetrators off. It says that the problem is in you. "You are broken; you are ill." We are not. We are having a normal range of responses to trauma, yet normal trauma responses are being pathologised. Then we are often forcibly treated, against our will. That can go on for years. I had the great honour of being able to move to this area where there was a broader acceptance of people with odd ideas of just being normal. I am no longer on community treatment orders, I am no longer being scheduled and I am no longer on enforced treatment because the attitude of the community here was acceptance and love.

We need services to be like that—non-judgemental services full of love. That is what peer work does. We love the people we are talking to. We sit down beside them and we are with them and we do have love. A peer worker lovingly challenged me and changed my life with one very short conversation. I was crying because I had been diagnosed—another diagnosis—with one of the serious and enduring types. I am a voice hearer. I also experience extreme anxiety, panic attacks and depression and all the rest that goes along with that. I was crying and this peer worker came to see me. She asked me why I was crying and I said, "Because of the diagnosis that they gave me, and because they also said, when they delivered that diagnosis, 'You need to change what you expect out of life because you won't be able to hold long-term relationships, you won't be able to work and you won't be a valuable member of your community.'" Those were the actual condemning words that I heard.

I've heard those words—or very, very similar—not just from one but from several psychiatrists. The biomedical model is a deficits-based model, rather than strengths based. That peer worker lovingly challenged me. She said to me, "Fay, I have that same diagnosis as you. But I work, I pay tax, I pay my mortgage, I support my family and I'm really active in my community. If I do that, why can't you?" And then she lovingly challenged me one step further and she said to me, "In fact, Fay, what gives you the right not to?" My life changed then. I stopped seeing myself as a victim and started seeing what I could do—started looking for what I could do—still with this diagnosis.

At that point in time, I still accepted the biomedical model of mental illness. I no longer accept that, not just for me but across the board. There is just so much evidence that trauma is what causes this, yet there is only one specialised trauma service that I know of in New South Wales, which is in Thirroul. It's a women's service; it's amazing. They de-medicalise people. They take them off their medications. They tell them that "The response that you're experiencing from the trauma that you've had is legitimate and real, and of course you would have that kind of response," and people start to heal.

That's the kind of service that we need, yet it's a private service that could only attract funding for one public bed out of the whole of New South Wales. We know that 87 per cent, at least, of the people who have diagnoses have had trauma. You just heard before it's not rocket science. It isn't. It's about providing the services that advocates have been asking for for 25 years. It's about not just listening to the so-called experts. We know who those two men mainly are, who love to hear their names on radio. I have great respect for those two men. However, I no longer have respect for services that cause trauma when they're supposed to be healing. They're causing trauma to the people who are already traumatised. They're diagnosing them and taking away hope. People are stuck on these medications, and then our physical health starts to decline.

I'm not shaking because I'm nervous, and I'm only shaking the amount that you can see today because I have the privilege of being able to afford prescription oils to try to stop the neurological disorder that I gathered from having enforced psychiatric treatment through the medications lithium, Epilim et cetera. Now you know my diagnosis with bipolar schizoaffective disorder. I didn't expect to live till I was older. People like me, on the kinds of medications that we're parked on, have a shortened life expectancy by between 15 and 27 years, depending on what research you read.

If a peer worker was in hospitals and they were causing trauma to people, they were causing them physical harm, they were causing their thyroids and their livers and their kidneys to fail, they were causing them to put on 20 to 30 kilos of weight that was leading to diabetes and heart failure, they were causing them to be disabled because of the unwanted side effects of how they were treating them, they were alienating them and they were giving them a diagnosis that was alienating them from their family and community, would the Government continue to fund peer workers to do that?

I don't think so, yet we continue down this biomedical model of treatment that's causing physical harm, trauma, to everybody involved in it. I shouldn't say everybody. Yes, every now and again there is a person who gets help.

The CHAIR: Ms Jackson, I am so sorry to have to interrupt you. The evidence you're giving us is extraordinarily valuable for our work. We've only got five minutes left and I did want to give the opportunity for Committee members to ask you some questions.

FAY JACKSON: Yes. I apologise.

The CHAIR: That's all right. My first one—you've obviously covered a huge range of issues. Early on you mentioned the need for alternatives to emergency departments for a significant number of people. This afternoon the Committee's going a site visit to the Safe Haven here in Lismore and I was interested in your perspective on the Safe Haven model and how well that's working?

FAY JACKSON: I think, like headspace and everything, the different Safe Haven models can have different cultures within those as well. But I think that that's a far better way than people going to emergency—A& E—where they're told very often that they're a waste of time and a waste of space because the A&E staff have to treat people with real problems, real health issues. So I think that that's really helpful to have that. However, I do think that we do need peer-operated services in the community before even that starts. Prevention and early intervention isn't just for young people. I need prevention and early intervention. I've had this diagnosis since

I was a child. It's changed—but it depends on which wheelbarrow that doctor's pushing—but I've had mental health issues since I was a child. Now I am 63, but I still need prevention and early intervention. I don't ever want to—I will never go back into hospital. I can't. I can't do it. I won't survive it. I won't.

We can't cause this to other people. It must stop. I'm just one. I'm just the example of thousands of people—what's happening to thousands of people every day. I have to get early intervention if I start to get rocky. I need to be able to just walk into a service without being afraid to go to a hospital. I won't go back to a hospital. I need to be able to find that service in the middle of town where I can walk in, see friendly, welcoming faces who will put an arm around me, come take me, sit beside me, ask me what's happening for me, ask me what's going on and say, "No wonder you're feeling like that, darling. We can help you." That's what peer-operated services do. They heal right from the first conversation and that's what we need to be doing. You'll see in the documents that I've given you pyramids of care, models of care that I believe will work far better because of what I've seen in other countries and because of what I've seen in Australia as well in peer-operated services.

We can do far better for far less money. For every $1, we found—there's been research done on it on returns on investment—every dollar invested into a peer-operated service returns a $3.27 return on investment. There's no clinical service aiming to do that. We need to be offering that peer support first and then clinical service is last, and then seclusion and restraint should never be there. The Mental Health Act must be changed. We have laws to protect people if there's violence, or whatever. We can use those laws without engaging the Mental Health Act. The Mental Act strips away our human rights.

The Hon. EMILY SUVAAL: I was just looking briefly at the pyramid of care. Thank you for your evidence, putting together this document, and for the work that you've done. You mention open dialogue at the top, which I was quite interested in. Could you explain for the Committee a bit about what that is and why that's right at the top? Because it's right at the top.

FAY JACKSON: Aboriginal people would say that it's actually just what they have been doing for decades, which is everybody sits around and talks and tries to find a way to support people and solve issues. But the official open dialogue model came out of Finland. I've been there, I've seen it operating, and it's beautiful. It's in keeping with the "nothing about me without me" that people with lived experience say. It is, I guess, what peer-centred services should be. At Flourish Australia, we talk about peer-led services, because in most people's experience in Australia, peer-centred services means that the person sits in the middle and the clinical services sit around them, telling them what they will and won't do, who they are and who they won't be able to be, where they will live, what they will take, what they won't take, what they will do.

In the open dialogue, they sit there with the person—and if it's a young person, with the person's teacher—with the person's parents, with the person's friend, with the clinicians, with the psychologist. They all talk together, working through, with the person leading, what they need—the young person, the older person, whatever, talking about what they need. And then they come to an agreement of what will be done to support the person to get back into school or get back at work. It's nothing about me without me. Don't make any decisions about me. Don't talk about me without me being there, that I can answer your questions or say, "No, your assumption is incorrect that you're making about me." That's what open dialogue is.

There is also another form of open dialogue that you may hear about, but that's more of a one-to-one, and that's a peer-run support—it's volunteer—where we teach people with lived experience of hearing voices to communicate, have an open dialogue with their voices and get to the basis of why their voices are carrying on. Yes, it's just getting down to the nitty-gritty of it all.

The Hon. EMILY SUVAAL: Thank you.

FAY JACKSON: And it heals. It really heals people. I know multiple—like, large numbers of people who were healing from psychosis without medications. I no longer take psychiatric medications. I don't need them because I've had healing through peer support.

The CHAIR: Thank you. I'm so sorry that we've run out of time. We could probably discuss the issues that you've raised all day. I did want to just briefly reassure you that we've had no questions for you about the clinic in Thirroul because we're hearing from Dr Karen Williams, who runs that service, on Thursday at our next hearing in Sydney.

FAY JACKSON: That's fantastic.

The CHAIR: Thank you so much—

FAY JACKSON: If you can't convince the Government to provide peer-operated services everywhere, then please convince them to provide services like that one but also to fund peers sitting within them as equal partners in the support and treatment of each person that they will be supporting and treating.

Ms SUE HIGGINSON: I know time is up, but can I ask: Where was the house that you said lost its funding?

FAY JACKSON: Hervey Bay.

Ms SUE HIGGINSON: Thank you.

FAY JACKSON: In Queensland.

Ms SUE HIGGINSON: Yes, I know. Thank you.

The CHAIR: That was a quick one. The secretariat will be in touch with you with any questions on notice. Thank you so much again for taking the time to put this document together and share with us your experience and your expertise.

FAY JACKSON: Thank you. I made all that document and intended to refer to it, but, typical of me, I didn't really follow to the script.

The Hon. EMILY SUVAAL: You did.

The CHAIR: No, that's all right. Thank you for tabling it. We can read it.

Ms SUE HIGGINSON: We got heaps of that. Thank you.

FAY JACKSON: I think, perhaps, that's an indication that services can't either follow scripts that the biomedical model has written. We need to follow the script of the individual person and their individual needs, no matter what their age, what their religion, what their gender and what their culture. Thank you.

(The witness withdrew.)

Mr ROB CURRY, Executive Officer, North Coast Allied Health Association, affirmed and examined

The CHAIR: Welcome. Thank you so much for taking the time to give evidence today. Would you like to start by making a short opening statement?

ROB CURRY: Yes, please. Firstly, I would like to acknowledge I live out the back of Wauchope. The North Coast Allied Health Association covers the same footprint as the primary health network, so it's from near Port Macquarie up to Tweed, obviously including the Northern Rivers. I feel a bit crumpled, sorry; I've driven a fair way this morning. Do I look crumpled?

The Hon. EMILY SUVAAL: Not at all.

Ms SUE HIGGINSON: You look fantastic.

ROB CURRY: I've driven through Birpai country and Dunghutti country and Gumbaynggir country. I'm here now on Bundjalung country and it's looking stunning at the moment, so it was a long drive but a pleasurable drive. It looks great. I acknowledge all those traditional owners. I'd like to also quickly acknowledge the previous speaker. I heard headspace, or part of that conversation, which I found very interesting and is relevant to my association in many ways, and also the peer worker—compelling engagement with you folks. I'm a health professional, so I apologise for that. I support peer workers. It's really a key part of what we need in the mental health space as well as any professionals. I'm a physio by background. I'm getting a bit older. I don't practice anymore, so I do things like a little bit of bush regeneration and my 12-hour-a-week role with the North Coast Allied Health Association. I've spent most of my working life up in the Northern Territory, mainly in Aboriginal health. I came down here about 10 years ago.

My association represents allied health professionals in the field. Not all members are allied health professionals; there are some allies who are supportive of the allied health people. But they're in the field right across the region and there are 20 different allied health professions or more. You know that, don't you? The allied health professional space is complex and it's many professions. It typically is tertiary-trained health professionals as a broad definition. "Not doctors, not nurses" is a negative way of putting it, but that's who we are. We have some key issues around mental health that we're concerned about. I hear about these principally through our people in the field, our practitioners in the field. The main ones in the mental health space are social workers and psychologists and counsellors in the allied health space, but it also includes speech therapists, occupational therapists, physios, sometimes exercise physiologists—others who come into significant engagement with people with mental health in the field, if that makes sense. The core people are obviously the psychologists and social workers and counsellors.

We have a number of issues that we're concerned about. One is just the general lack of mental health workforce in rural areas, including on the North Coast of New South Wales. You, again, would know that. The Institute of Health and Welfare and, previously, Health Workforce Australia describe in great detail their relative lack of mental health workforce in these regions, so I'm sure you're aware of that. Limited access to child mental health services—this is key for us. I heard the headspace discussion and we share a lot of the points raised there, but for us the key area that is lacking at the moment is for kids under 12 and their families. There is a shocking lack of services for that group. Everyone knows this. This is not unknown to anybody who lives in the community as far as I can tell. Also, it's pre-headspace.

Headspace is an organised response to young people with mental health problems, but prior to that there is not an organised response to mental health, so families just battle it out. Obviously I'm saying "families" because parents are in it up to their ears with their kids. Their kids are manifesting mental health issues or difficulties. You need to work with the family, with the parents and with the kids, and the services just aren't there. In this area, there's a program called Resilient Kids through the PHN—which is just starting out—so that might start to really help in that space but, fundamentally, around Australia, and particularly in this area and particularly around the Coffs Harbour area actually, there's a really long waiting list to see mental health practitioners. In this area there are high rates of medication—psychotropic medication—for kids. That's simply because the GPs don't have anyone to refer to so they have little option but to use medication. It's also an early intervention space. If you can work on families and kids or support them, then you help to prevent chronicity, or you hope to prevent chronic lifetime problems with mental health challenges, so it's logical to invest in that space. It's not there at the moment. We can give you data about that—long waiting lists et cetera to see people.

Quickly, our other issues are mental health care for older people. It's not well organised. It's under-resourced. The royal commission made recommendations to the States around that issue. We want to see more training for all health providers in trauma-affected care—not just mental health professionals but for everybody—because trauma is such a common theme or a common issue in the community. Mental health services for the Aboriginal communities—here we could say something like, "Look, it's a Commonwealth responsibility, and we can wipe our hands. It's not a State responsibility; it's a Commonwealth responsibility." I reckon that is indicative of one of our biggest problems—our services are not integrated.

If you look at this town, between the not-for-profit sector, the private sector and the government sector, there's hardly any communication in the field. There must be linkages made there on behalf of families. Also, if there are not enough private petitioners, for example, meeting needs, I would expect NSW Health, for example, to lobby for those private services because if they don't it all comes back to the ED department and hospitals and New South Wales services. It's all connected but were not making the connections. That was my final point really—about the need for integrated care in local communities. We have a community here. All of the workforce should, in some way, be linking productively with other parts of the workforce. I'm happy to talk about any of those issues in detail. We have suggested a number of potential solutions in our paper, but I won't talk about those. I'll throw to you guys to ask questions if you have them.

The first thing I want you to know is who I represent. We're arm's length. Our organisation is not so much about the allied health professionals; we want to make sure there's good access to allied health services and those services are of quality, and the way we seek to do that is through supporting our allied health professionals, if that makes sense. We're not a professional association like the physio association or the AMA—that's not what we do. Over to you guys, thanks.

The CHAIR: Thank you so much for the detailed witness submission that you've prepared, as well as the time to give evidence today. I have a couple of questions. The first one is in the context of the workforce shortage, and we've already heard evidence to this inquiry about the rates of burnout for health professionals. In your submission you talked about the need for more clinical supervision or debriefing. In practice, what could that look like? How does it work? Do you think we need to have more clinicians in the region who can provide that support to your members or is it something that could be provided externally? How do you think it would work in practice?

ROB CURRY: Who should provide? That's a good question. I think NSW Health can lead on that. It's hard for the private sector to lead on it. There's no coordinating body of private allied health professionals anywhere in Australia, really. I'm not saying it's the Wild West, but the practitioners work by themselves; they're not supported the way GPs are. The Federal Government has not fully acknowledged its relationship and responsibilities around the provision of allied health services. Even though people do organise themselves in the private space for CPD et cetera, I think it's going to be entities like mine—voluntary representative entities—and people like NSW Health that'll have to lead on this, or the PHN offer good quality, trauma-informed care training for all health professionals. People are crying out. We have run a couple of sessions. We link with Phoenix Australia, who are experts—they're in Melbourne—to help us deliver CPD on that. But I'm talking about training here: some decent quality training for all health professionals engaged with the public.

The CHAIR: In your submission you talked about the recent recommendation around outreach for older people, but also visiting school settings for younger people. I think that there has been a real theme within the evidence we are receiving about meeting people where they are at, rather than asking people to come into a clinical space. What you think are the current barriers to that outreach happening, and how do we address them?

ROB CURRY: In schools—talking about the under-12s, the kids and families that are not getting adequate support at the moment, it would be a great place to invest, to have some mental health resources, human resources in that space, so that teachers then can engage with professionals, and peer workers and support workers, and pick up that slack. But it also means that they can then engage with the private sector. If I was a part-time psychologist in a school, for example, and there's a counsellor there, I might say, "Well, I think you need an intensive course of therapy," so refer to the private sector under Medicare. That can be done, or the issues can be resolved pretty much in school if the teachers have that professional support from psychologists. So I think investment in some core resources in the schools, particularly in primary schools, would be of enormous benefit. Do you think? I think it's logical, isn't it? For some reason, we haven't gone down that path.

The CHAIR: I'll get in trouble if I let you ask the questions, I think.

ROB CURRY: Well, I won't say that you nodded.

The CHAIR: That's all right. You can hear what I think once we finish the inquiry.

ROB CURRY: But my point again, though, is that it just seems logical that you would invest there. And it would be a great space, too, for families to engage, not just with private practitioners but in a community sort of space.

The Hon. SUSAN CARTER: Thank you for your time. A number of people have discussed workforce issues. They seem quite acute in this area, but they seem to be present in other areas as well. From the perspective of your members, do you have any insights on why there is difficulty, for example, attracting sufficient psychologists to the North Coast? Is it money, is it lack of professional development opportunities, is it that nobody wants to live on the glorious North Coast? What are some of the drivers that prevent an adequate workforce?

ROB CURRY: Traditionally it is hard to get health professionals out of the cities. We all know that. But we have a particularly attractive area. If I was wanting to work in child psychology, for example, it's very difficult for me to have an adequate income under Medicare to treat the child, because I need to work with the parents as well, and the school. The current funding mechanism is not supportive of that practice, so people avoid it. They'd rather see adults because it's more straightforward and more cost-effective for their business to do that. Does that make sense? Were you aware of that?

The Hon. SUSAN CARTER: I'm asking you the questions to try and find out.

ROB CURRY: Sorry. In other words, there is a structural problem in the current Medicare system. It has nothing to do with the States in particular; it's to do with the Federal funding. But in terms of recruitment locally, I think each region can do a lot to recruit people. For me, it would be stuff like setting up communities of practice that invite people into the space, setting up good quality training for counsellors and psychologists in this area, that would invite people—

The Hon. SUSAN CARTER: Is that a role that your organisation could be involved in, given that you gather together allied health practitioners, to set up that community of practice?

ROB CURRY: We are only a small organisation, so we lack capacity. I tell people that we've got somewhere between 100 and one million members, which is not true—but it is closer to 100. We would like to get into that space, but we don't currently have the capacity.

The Hon. SUSAN CARTER: Can I ask you a question about peer workers? We've heard a lot of comment about peer workers. Do you have any views about whether there's, if you like, a one size fits all? Is somebody with lived experience of one type of mental health issue able to be a peer support worker for somebody with any type of mental health issue?

ROB CURRY: I wouldn't personally have the expertise to comment on that, except to say that I, and we, think that peer workers are a key part of the picture, as the other lady explained. It's not just health professionals. I'm here advocating for health professionals, and people need that expert advice. But that's only part of the picture, as are psychiatric services. But peer workers have to be a key part of making this whole area work, I think—the really human, accessible part of it.

The Hon. SUSAN CARTER: In terms of making it work, what's your observation of children, adolescents and families? Are the families brought in as part of the greater whole to work with the child and the adolescent or are they kept at arm's length?

ROB CURRY: At the moment, there is very limited resource for parents. But then you could envisage that you could do work with parents as a separate theme.

The Hon. SUSAN CARTER: I guess I'm asking you do you perceive that that's happening at the moment or is that an area that we could look at developing?

ROB CURRY: It's an area that needs to be developed. There is a GP in the Coffs Harbour area that voluntarily does parental training and support at night after her general practice, but that's volunteer. There's no funding for it. It's much needed though.

The Hon. EMILY SUVAAL: You mentioned that you have somewhere between 100 and one million members. Are you able to tell the Committee how many members you have?

ROB CURRY: We started in about 2015, and we have about 140 members. And they're not all mental health; they're speech therapists and—

The Hon. EMILY SUVAAL: That was my next question. You mentioned social work and psychology as being the predominant allied health workforce in mental health. How many would you say are working in mental health currently?

ROB CURRY: Probably 20-odd. Most of our members are physios, OTs, speech and exercise physiologists et cetera. Some of them work in the mental health space, but they're not core mental health workers like the psychologists are.

The Hon. EMILY SUVAAL: Any dieticians?

ROB CURRY: Yes, plenty.

The Hon. EMILY SUVAAL: What would you say the role is, or what would your members say the role is, of dieticians in the mental health space?

ROB CURRY: Again, I'm probably not expert to respond to that but to say that many people with mental health challenges have dietary issues as well and can be supported in that way, as they can by exercise physiologists with exercise et cetera. The evidence is probably not direct there, but it's certainly an important aspect of their overall health care. Can I just mention something about the Aboriginal situation? I mentioned it at the beginning, saying it's like they're two separate worlds in terms of meeting that need. But it would be great to see additional allied health provision or access to the Aboriginal health services in the region. They have very limited access to psychologists, physios, OTs et cetera. It is expected that the Commonwealth will fund that but, where they don't or haven't, there's a gap. And we're not filling the gap.

In our local community, where Aboriginal people live, that need is not being met, even though there is an expectation that the Commonwealth will meet that need. It would be great, when we're talking about integrated care, if the Commonwealth and the States, or New South Wales, came closer together to resolve that issue. They need services that are culturally safe. AMSs like to draw, say, a psychologist into their service or into their practice—their way of doing business—in order to deliver that service, rather than clients going out to private practice spaces or whatever. That would be a huge thing for the Aboriginal community, if the AMSs had more access to contract or put bums on seats and get allied health people into their practices. It would make a big difference, I think, in terms of access. Does that make sense?

The CHAIR: Yes. I had another question from your written submission. You talk about this idea of a collaborative allied health practice. We have had previous evidence about the PHN collaborative GP practices. What would the nuts and bolts of that look like? How would a collaborative allied health practice work?

ROB CURRY: We think it could work. With GP practices, they have traditionally had a lot of support from the Commonwealth through divisions of general practice and PHNs et cetera. Their principal focus has been supporting general practice. We would like to see the Commonwealth, through the PHNs, support allied health practice in a much deeper way so those services can combine better and deliver better access to the public. For example, we'd like to see digital health supported in those allied health practices. There is very little digital communication with health. Communicating health between doctors and allied health professionals and hospitals is still very awkward despite My Health Record et cetera. We'd like to see investment bringing allied health into that space so the patient doesn't have to keep saying what has happened. It's there in the medical record; the doctor and the allied health professional and the hospital are communicating efficiently, the way we should be in 2024. That's not happening and that investment hasn't been made. I don't know what NSW Health can do about that, but it certainly needs to happen, I think.

The CHAIR: Thank you again so much for your detailed written submission and for your time and the long drive that you've made to share your experience with us today.

ROB CURRY: Thank you. The process has been interesting. It was good to hear the other speakers as well.

The CHAIR: The secretariat will be in touch with any questions on notice.

(The witness withdrew.)

Mr JOEL ORCHARD, Executive Director, Wardell CORE, affirmed and examined

The Hon. SUSAN CARTER: Thank you very much, Mr Orchard, for being with us today. Did you have a short opening statement?

JOEL ORCHARD: Sure. Firstly, I really appreciate the opportunity to come and discuss a little bit about our experience. I represent a very new community organisation that was founded in direct response to the recent flooding event. Wardell is a very small community on the very lower part of the Richmond River, so, by circumstance, we saw all of the floodwaters from the rest of the Northern Rivers go past our small town. We have established, essentially, an informal neighbourhood centre. We exist in a vacuum of support services in a rural area with no real direct access to other support services. Effectively, we've become a one-stop shop providing the full gamut of community support, social support services, disaster recovery support, links to all the formal and informal government support and recovery services—and predominantly focused on community health and wellbeing.

We've relocated to an independent building and we've established ourselves now in the community to try to provide a full and complete wraparound support service. We continue to provide crisis management, links to case management and RSS. We've got our own internal dedicated mental health support service, with six days a week of counselling available to the community free of charge through a grant tender through Healthy North Coast. Then, with a range of other grants and other support programs, we've been able to offer quite a complex and comprehensive support service—everything from therapeutic horticulture to social eating opportunities to peer support training for community members.

Food relief is a really big part of what we offer now as well. Increasingly, we're seeing the compounding impacts of the disaster, with the cost-of-living crisis having cascading effects on people's mental health and then the exacerbation of preconditions of things, like domestic violence—the rates of presentation even in the past 12 months in difference to the first 12 months have escalated substantially. Homelessness and housing insecurity is clearly having a massive impact on the health and wellbeing of people. We are trying to provide a very place-based solution, and by the book, with recommendations from all levels of government around the benefits of the bespoke opportunities that community-led recovery organisations can offer; really look to integrate our community into their own recovery best practice to be better prepared for future disasters; and I think offer something that is very relevant to the people of our region.

The Hon. SUSAN CARTER: I am interested in your name—in the fact that you've got "resilience", if you like, at the core of your name. Could you perhaps give us a couple of observations about the relationship between resilience and mental health?

JOEL ORCHARD: Sure. I think initially—our own organisation has had to evolve. That has been a natural process. It was very unclear, in the beginning, how long the different aspects of recovery would take. What was very clear from the outset, due to the scale and nature of the disaster, was that it was not going to be a short-term fix. Resilience, to us, is represented by the immediacy. Although we are not a combat agency by any extent, we are still a recovery agency. Resilience is the growth and development of people's own abilities to recover and then to fortify themselves for future events.

It's very clear to us, from our place and geography, that we are in a region of very high risk to future severe weather events. I think that has been well documented. We are at extreme risk of riverine flooding, extreme risk of ocean rising and extreme risk of future severe storms, so we're ensuring that our community is well prepared now, with their own mental health and wellbeing, to withstand what could potentially be another impactful disaster even in the next 12 months, and then futureproofing by integrating youth voices into our mission and hearing from the local community what they feel would better prepare them for the future.

The Hon. EMILY SUVAAL: Thank you, Joel—I hope it's all right for me to call you Joel—for appearing today and for all the work you do on an ongoing basis. I wonder if you could explain to the Committee what is the usual context within which people seek support from your service, and also whether this has changed over time.

JOEL ORCHARD: There are a few facets to the question. When we analyse some pretty basic but raw data—we capture, on presentation, every person who walks through the door roughly where they are from, why they have come to visit us and what support services we have been able to provide—we have seen some changes in that over time. We are fortunate in that, because we are an informal service that has stepped into the space, we have been able to define our own parameters around who we support and what resources we have to provide, but we have never put geographic limits on the services that we offer. Whereas in difference to some of the other support services around, they have had to limit it either by postcode or geography or for whatever reason—that's where their funding is limited.

We have focused on our immediate community, but an extension from Broadwater, which is the next village upriver, all the way through to Ballina and Ballina inclusive, which has put a huge burden on our very small team and very under-resourced organisation to cater for a really large geography and a very large population. I think it's worth pointing out that the Ballina LGA is the only shire in the Northern Rivers without a neighbourhood centre. We have filled, in a sense, that gap as well. We have had to, by demand, cater for a large population of the West Ballina community that don't have their own dedicated community flood recovery support service. So we get people who will transit out to Wardell to access help and support.

We are inclusive of the Cabbage Tree Island community, which is a large population of people who have been completely displaced. Broadwater itself is a village about the same size as Wardell that doesn't have any continuity of care at all. By geography, we cater for a large area. There are a number of small, rural centres, plus a large, rural area, so we are catering for a lot of people within the cane farming community as well.

In terms of the demographics of those people as well, our mental health service doesn't cater for under-16-year-olds. That's outside our scope. But we do cater for family support, which includes children. We provide, through some youth support funding, some dedicated youth programs. That's a way we can integrate community needs and the children's needs, and then provide better pathways of referrals on to dedicated youth support services. In that way, we are sort of a first line or a first point of contact for a lot of people.

What I really value about the way we've designed our service is that it's holistic and it's vertically integrated. So somebody might present simply for some company, and we know that social isolation and loneliness is having massive impacts on people's health and is horrendously exacerbated by this disaster. In fact, a lot of people are just now starting to present for the first time, so have taken this amount of time to feel comfortable venturing out of the home or venturing into the community to access help, support and company.

We can greet them at the front door. We can refer them to peer support and a cup of tea. In that moment we can identify if there's any other critical needs that they may have, provide immediate referrals to case management, to financial counselling, to domestic violence services or book them an appointment with a counsellor. We can also register them for tai chi or a qi gong class or a meditation program that we have every week, or into a number of other social connection activities that we have. Then, by the time they've left one or two hours later, they've got a parcel of food and a whole range of appointments. I think the ability for us to integrate all of that in one place has been so dynamically successful for the community that we support, that I honestly couldn't see a better way of doing it, at this stage, at the scale that we're at.

The Hon. EMILY SUVAAL: Essentially, it sounds like a hub.

JOEL ORCHARD: We're absolutely a hub, yes.

The Hon. EMILY SUVAAL: I wonder if you have any data or could perhaps comment on whether you have seen a change over time in what services people are presenting for, particularly with cost-of-living issues: whether it was first just for a cuppa, now there's more need for food or clothing or things like that?

JOEL ORCHARD: Yes, we do have data. I can absolutely follow up with a report that can give you the date-by-date data that we've got every quarter. We presented an annual report, and we can now compare this year—the data we're starting to gather from presentations—versus last year. Anecdotally, it's very clear that people are now spending a lot more time when they come to visit then they had in the past. I think the urgency of need initially meant that we had really high numbers of throughput of clients accessing things quite quickly. It was grab what they need and get on with it. I think the aspect of social connection now is becoming more and more important.

We're now probably seeing more presentations of a different form of crisis. Initially, it was flood recovery crisis. Everyone had their own kind of crisis, but now we're seeing more systemic challenges that are presenting as more complex cases of crises. We see people now presenting with a whole gamut of challenges, rather than it just be targeted at flood recovery. They might have initially come in because they were desperate for clothing, food and towels; those were easy solutions we could offer. Now it's people coming in who are homeless or having extreme levels of housing insecurity; are most certainly financially insecure or destitute; are presenting with domestic violence and severe post-traumatic stress disorder symptoms as well. Those are very difficult clients for us to cater for.

We're most certainly seeing a much higher increase of rates of suicide and suicidality, which is a really difficult thing for, essentially, a team of volunteers to cater for. We're really fortunate to have extraordinary staff in our mental health team, who are, at six days a week, completely overwhelmed. They're working well beyond their scope, and we're constantly having to check on their health in order to be able to manage the caseloads. In part, that's because of the extreme need for them to cater for everything in-house. There's literally nowhere for us to refer clients to at the moment. And in many cases, all of us—myself included and the other staff that provide informal case management—will take on a load of responsibility to support those clients because it's much more productive for us to manage in-house than to send them on to a service that may or may not contact them in a relevant period of time.

We've had people, like, literally lose it—I mean, I don't know how better to describe that—just because they're sitting on call, waiting for a support service. They can do that in our comfort, with company; but, you know, that impact on people who are already at breaking point of their mental health is extreme. So trying to monitor that carefully, compassionately, professionally within a very complex community environment, especially where people are constantly engaging with their friends and neighbours—there's no anonymity within that environment.

We're certainly able to provide professional discretion. People have privacy with the clinic rooms and there's privacy with entries and exits, so we're able to cater for that. But in part I think also the fact that it feels like a second home to so many people—we've broken through a lot of the stigma to accessing those sort of support services as well that people feel really comfortable to be quite raw in their experience, which in some ways you would say is a beautiful gift that people have come a very long way to being able to express themselves. It's deeply healing for everyone. I know that's a roundabout way of answering your question—but I think to paint a picture of the spectrum of what we're dealing with—

The Hon. EMILY SUVAAL: Do you see the same people over and over, or is it different?

JOEL ORCHARD: Very much a spectrum. To that point, we have quite a lot of people that really need the continuity and we have a lot of people still presenting for the very first time. There's a lot of very stoic people who have felt deeply uncomfortable about accessing support and services that have had to take a very long time to come and ask for it. Unfortunately, in a lot of cases they have reached the breaking point with their finances, with their life and lifestyle, access to work or inability to work, before they come in asking for help, and then they're more difficult to support. But I think the feedback that we get from the community is that the value of having a place that feels so comfortable that they can then access things that they would never have dreamed of—including just general food relief or a mental health counsellor—has meant the barriers to them accessing help are much lower.

The Hon. EMILY SUVAAL: Thank you, Chair.

Ms SUE HIGGINSON: Thank you, Joel, for everything you're doing. I have watched the journey of CORE and it's been quite amazing, really. So thank you to you and your teams for bringing that journey all the way from day one, really, of the flood crisis. I just wanted to ask, if there was something that government could do for CORE, what would it be? What would your priority/wish be for government to do kind of immediately?

JOEL ORCHARD: I could give you a long list, but to prioritise, I think it was very clear to everyone the scale of this disaster was going to demand quite an extensive recovery. Very early on there was no concrete language to describe the duration of recovery that was meaningful to people. Being able to articulate that to the community and all of the support services early on would have helped link that to resourcing that was genuinely necessary over a sensible period of time. All service providers that I'm aware of are constantly staring down the end of a funding cliff, knowing that there's nowhere to send clients if you run out of funding, and we're included in that.

We were very fortunate to get a two-year funding from the beginnings, which felt like such a long lifeline. But realistically what everybody needs is five years of continuous funding with an exit plan. So we need transitionary support. As a community support service that's very new, we're very aware of grant dependency and how challenging that can be. We're really interested in looking at establishing ourselves as an ongoing support model that can use social enterprise or create other forms of revenue to sustain our services so we're not dependent on government funding, but that needs resourcing and support in itself.

I think, from my reading, that all levels of government document that it's the role of government to enable communities to lead their own recovery. That seems to be very well written and researched, and yet not very well delivered. I think as a community recovery support service that's trying to lead by that example, we feel very unsupported in many ways by government, and certainly not enabled to do what we're clearly very good at doing. I think the impact that we've created speaks for itself, but I'm not sure that the frameworks that Government has to enable communities to do that work themselves are being acted on. I think there's definitely a space for someone to look at why that barrier is between language and actualising. I think it was also really important to note that, when we established, we went looking for models, for case studies and for research around how communities can do what we've done, and there isn't a road map or a template or a very clear pathway or even a third party or external community agency, like a peak body, to support these kinds of organisations' development. And I think that's a really critical missing piece, specifically in New South Wales.

We lent heavily on the Tasmanian Neighbourhood Houses association, who were so supportive and very forthcoming with all manner of practice, development and governance frameworks and all of the kinds of pieces of paperwork that you need to establish, which is so hard to manage when you're in the midst of a disaster. But we got there. South Australia has some really great research, and in Victoria, following the bushfires, there are some really great detailed reports. There seems to be nothing in New South Wales, and I think that's a massive gap that could be pretty quickly solved simply by talking to the organisations through this disaster that have been successful in creating meaningful and useful programs. I think documenting the success stories and analysing what's working well and why would help other communities in other areas to more rapidly move into spaces where they can offer better, more competent community support. I imagine those are the three things I'd probably put forward.

Ms SUE HIGGINSON: You mentioned Cabbage Tree Island. What is the relationship that CORE has with the First Nations community there?

JOEL ORCHARD: I would love to say that we had more resources to be more effective in that relationship. It's been a priority for us to have a very open-door policy to supporting Indigenous members from the community to try to demonstrate cultural sensitivity to their needs. At this stage, we don't have a specific Indigenous liaison or any kind of program to support that community. I think, fortunately for them, they've maintained quite a comprehensive support program themselves through the Uniting support service that is coordinating the village, and I think, in many ways, the Cabbage Tree Island community has been always empowered to look at working with their own community to develop their own support, which is a good outcome for them.

Bit by bit, we are looking at ways we can create more activities, especially through youth and children, where there are just better things for the kids to do. We find when we put on youth activities, definitely, we get more engagement from that community. We are just up the road, so it's easy for us to drop in and have a chat with the Elders there to see if there are things that they need. We share resources and we have discussed running a number of programs on their site or on ways to get them more involved. I think it's just been a little bit of a rush just to do the stuff at the level of intensity that's been needed to really concentrate on deepening that relationship, which was clearly quite fragmented before the flood, and I think that there is a lot of work to be done in providing a much more safe environment for the Indigenous members of our community in Wardell.

The Hon. SUSAN CARTER: This is me thinking aloud: We've heard some different examples of the hub model, and I think you've established a very interesting example of that in Wardell. In a sense, in terms of government, Service NSW was really set up to be a hub for government services. Would there be any synergy or benefit to what you are trying to do if, for example, one day a fortnight, Service NSW could co-locate with you to help people navigate through some of those Service NSW activities?

JOEL ORCHARD: Yes. Service NSW had remote delivery early on. The accessibility to that support, I think, disappeared or evaporated from the Wardell community far too quickly. There were limited public transport options for people to get to Ballina—to the service centre—where that's still available and ongoing. Clearly, the flood impacted people's ability to transport themselves, and there was a lot of loss of vehicles and things like that. So transport has definitely been a barrier.

The reconstruction authorities probably became the more relevant group from the State agencies for people that needed to access that help. Then with a lot of the confusion that evolved around the buybacks and retrofitting and things like that—there was a lot of confusion in our community that hasn't really seen that funding trickle down the river far enough. At a point I guess people just resign to the fact that it wasn't going to happen and they've now started to look at how to recover their homes independently. So we've seen a transition. I think Service NSW probably would have been much more effective to work in better partnership with us. They always felt quite as an aside. At a point they positioned themselves in a different building, so community members had to go between the two for different offerings. We clearly could've accommodated them in our building. I think having a better relationship with Service NSW at that time would've been much more effective for everyone.

I'm not sure why it felt like there was a separation between what we were offering and what Service NSW were offering. Not specifically to Service NSW, but there was certainly an issue with all of the government services early on that we saw just this revolving door of new faces and new people, and it was very confusing to us and to everyone—who to talk to about what? It's been a high priority to us to provide continuity of care and, unfortunately, I think the high turnover of staff—or for whatever reason, government services have completely the opposite effect. What we know clearly is that anyone who has to repeat their story and re-walk their trauma history time and time again entrenches that challenge and it disenfranchises them from accessing those formal and traditional support services.

I had a very fortunate opportunity to work in north-east Victoria after the bushfires, and it was very apparent how important continuity of care was so that people didn't get re-traumatised. We've provided that with what we offer at the community hub, and that seemed quite at odds with what was available through government services. So I think that could certainly be identified as a challenge for people.

The Hon. EMILY SUVAAL: You mentioned earlier in your evidence that Ballina doesn't have a neighbourhood centre. I don't know if you can comment on why that is the case, or if there is indeed a need for one.

JOEL ORCHARD: I would say there's absolutely a need for one. I would argue there was definitely a need for one before the flood, based on a wide range of demographic evidence: from an aging population, lifestyle disease and socio-economics. My understanding historically was that there was a form of neighbourhood centre in Ballina. I'm not entirely sure of the history of why that dissolved, but there's been a large period of time where there's been a substantial gap. I think there are a lot of complementary services providing what parts of a neighbourhood centre would offer, but the fact that they're distributed and they're not embedded in the community, like a neighbourhood centre is, is why there's now a need to look at resourcing one. I have tried to stimulate conversations through our local member, Tamara Smith, about how we can look at solving that as a problem. I think there's definitely an appetite and interest from the community at large to look at that issue.

I'm hopeful perhaps in some ways that what we're doing in Wardell will be a catalyst for a more formal neighbourhood centre that can provide those support services in Ballina. Wardell is interesting in its placement in that we're right on the edge of our local government electorate, our State government and Federal electorate, and in the boundary of the Mid Richmond Neighbourhood Centre, which is based out of Evans. So we're kind of not really a focus or within the catchment of anything. In that way we've provided what we can in the space where we are, but now the evidence is very clear that Ballina has missed out and the residents of Ballina, who are still struggling with home recovery, given that they're in a larger city with what you would consider better access to services, are still having an extremely difficult time with their recovery, especially when compared to Lismore, which has quite a large gamut of support services available to them, even though they're overwhelmed as well.

The Hon. EMILY SUVAAL: Just a follow-on question: Is there a role for neighbourhood centres in that community mental health space? Would you have the postcode data which would suggest where people have come from to access your services and if that has changed over time and your catchment has grown?

JOEL ORCHARD: Not postcode specific but by suburb definition—we have that data for sure. We can see that over time. From my understanding of the data, I don't think it's an extreme shift. The areas which have been accessing the help are reasonably consistent over time. I think from our latest data, just over 50 per cent are from Wardell and the rest—50 per cent—are split from Ballina all the way through to Broadwater and all the little rural areas in between.

In terms of a neighbourhood centre, from seeing the results of the impact that neighbourhood centres widely have provided through the disaster recovery and my relationship to the neighbourhood centres from Murwillumbah, Kingscliff, Evans Head, Mullumbimby, and even over this way in the community gateway, there are really clear examples of how impactful those kinds of organisations have been—able to rapidly generate the right kinds of help for people. I think there's really good evidence to say that neighbourhood centres are really functional aspects of community-led disaster recovery and really ought to be considered for future disaster planning as a more integrated component of disaster recovery and resourced accordingly, rather than what's seen at the moment, which is that they just have to pitch for what grants are available and hope that they're best equipped to access that resource.

The CHAIR: I've got one last question. Wardell CORE is obviously an example of the benefits of a community-led approach to providing a mental health service so I appreciate the irony of my question but which, do you think, are the parts of that service that might be replicable in other areas?

JOEL ORCHARD: I think probably the best part about it is the holistic nature of it rather than the individual parts. I think the greatest impact that we're having on people's health and wellbeing is the fact that we can offer all those things in one place which is comfortable and which feels organic. I mean, the difference between us—we're not a clinical environment. There are no uniforms. People come in. We exist in an old bank building and it feels like a home. There are couches and it's very easy for people to access. That in itself, I think, is widely replicable and it's also scalable. What we're offering would be just as relevant at a larger scale as it would be at a smaller scale.

The fact that it's owned and led by the community itself—so we're an incorporated association. All of our board, our staff and our volunteers are all local people and almost essentially all of them have been affected by the flood themselves or are still in various stages of their own recovery. Our association's membership consists of about 300 of our local community members. So that gives us the ability to discuss with the people that benefit from the service the most about exactly what it is that they need and we are able to reflect that in their way that we deliver services. I think it's not so much the aspects of what we offer that have the greatest benefits to other communities but the system that we've created. I don't think it's particularly novel but it works very well for what we're doing and could easily be replicable elsewhere. I'm personally very interested in looking at blueprinting what we've done so that we can hand that, as a very simplified document, on to other communities who may be impacted by this similar kind of incident so that they don't have to go through the rapid learning that we've had to go through and butt their heads against all of the challenges and barriers.

There are simple things that we put in place early on which have had dramatic impacts on our ability to be successful. Simple things like incorporating meant that we could open a bank account which meant that we could apply for grant funding, which meant we could have our own public liability insurance, which meant that we could lease a building. Whereas other community organisations that have required auspice agreements or have been informal for long periods of time haven't been able to access those simple building blocks which have and enabled us to then become a much more comprehensive organisation, even at this point, which is still quite short term. We have become a registered charity very quickly. We have great accountability. We have all of the checks and balances in place to be an organisation that could have existed for 10 years, but we've done that in a very short time.

With support, community organisations could get to where we've got to in an even more compressed time line, which obviously has huge benefits for the people who need the help and, arguably, from your perspective, saves government an enormous amount of money. We are a very lean operation, and we've had a huge impact. If government had to invest in government wages to do what we have done, it would've been at magnitudes of cost much higher, so this is cost saving for everybody.

The CHAIR: Thank you so much for your time today to share your experiences with us and for all of the work that you are doing.

JOEL ORCHARD: Thank you very much. I appreciate the opportunity.

The CHAIR: The secretariat will be in touch if there are any questions on notice. That concludes today's hearing.

(The witness withdrew.)

The Committee adjourned at 15:35.