Rockhampton Consultation Report

Regional Relationships and Engagement | 25–27 August 2025

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Organisations engaged: Rockhampton Senior Citizens Club, Bridges Health & Community Care, Central Queensland Hospital and Health Service peer workers, Central Queensland Indigenous Development, Men's Walk and Talk, The Compass House, Gumbi Gumbi AOD Recovery Service

Content note: This report discusses experiences of mental distress, suicidality, incarceration, racism and the removal of children from families. Please read with care, and reach out to your supports if you need them. The names of MHLEPQ members and community members with lived and living experience have been changed in this report to protect their anonymity.

About MHLEPQ and the Psychosocial Peak Body

The Mental Health Lived Experience Peak Queensland (MHLEPQ) is the peak body for people with lived experience of mental health issues in Queensland. Membership is free and open to any Queenslander aged 18 or over with direct personal experience of mental distress or suicidality. We provide policy advice and systems advocacy for consumers of mental health services of all ages, with a deliberate focus on voices that have historically been silenced or marginalised. Our work is guided by the movement principle of "Nothing about us, without us", and by equity, access, cultural safety and human rights.

The Psychosocial Peak Body (PPB) operates under the MHLEPQ umbrella. The PPB represents Queenslanders living with disabling psychosocial experiences and works alongside the community-managed psychosocial support sector, so that lived experience shapes disability and mental health reform: the NDIS, foundational supports, and related state and national policy. Our published submissions and advice are available on our website.1

We travel to communities because systems advocacy is only as good as the relationships and truths it is built on. Decisions made in George Street Brisbane or in Canberra land hardest on communities furthest from those rooms. Our job is to listen, and to carry what we hear into them.

A note on attribution. The assessments policy, funding and service design in this report are our interpretation and collation of discussions. They are drawn from the visit as a whole and from our wider advocacy, and should not be read as the views of any named service, organisation or individual.

About the Rockhampton Area

Rockhampton sits on the banks of the Fitzroy River, Toonooba, in Central Queensland, around 600 kilometres north of Brisbane. We acknowledge the Darumbal people, the traditional custodians of the lands and waters on which Rockhampton stands. Sovereignty was never ceded. Darumbal connection to this country was formally recognised through a native title determination in 2016, the culmination of a decades-long journey, and the dispossession that made that journey necessary is part of the story of distress and disadvantage in this region today.

With a population of around 80,000, Rockhampton is the service hub for the wider Capricornia region, known as the beef capital of Australia, with an economy spanning agriculture, mining services, health and education. The city hosts the Central Queensland Hospital and Health Service and sits near the Capricorn Correctional Centre, which makes post-release transition support a distinctly local issue. Like much of regional Queensland, Rockhampton communities carry housing pressure, cost-of-living stress, and thin markets for psychosocial and NDIS supports, with surrounding rural communities relying on the city for services that are already stretched well beyond capacity.

Services and Communities We Engaged With

Rockhampton Senior Citizens Club. We met secretary and MHLEPQ member Geoff and the five volunteer kitchen staff who run the club's weekly events. The club has become an unintended frontline: NDIS and Supported Independent Living

1 Mental Health Lived Experience Peak Queensland, *Policy and Inquiry Submissions* (Web Page) https://mhlepq.org.au/policy-inquiry-submissions/.

(SILS) providers bring people with complex needs to its events while clearly providing low-quality services and supports, including inadequate nutrition and cooking facilities. Community volunteers told us they do not feel prepared to support people with complex mental health needs, and they should not have to be. We provided MHLEPQ engagement resources to the club, and Geoff has offered to provide a statement when needed for advocacy or submissions.

Bridges Health & Community Care. Liz Downing-Moran and colleagues, including a First Nations identified team member, shared Bridges' community-based mental health, post-carceral transition, and alcohol and other drug rehabilitation and harm reduction work. Bridges has invested in a framework for practice led and developed by lived experience consultant Helen Glover, and its Recovery Support Program supports people with moderate to severe mental health issues who have been incarcerated in the Capricorn Correctional Centre.

Peer workers, Central Queensland Hospital and Health Service. We met Mel and Dana, both MHLEPQ members. Their peer work team is growing but remains small, four workers stretched across Rockhampton and Gladstone hospital services. The communities they support have limited options for peer and psychosocial support, and many people they work with want to change the system but do not know how to get involved.

Central Queensland Indigenous Development. CQID spoke to the experiences of First Nations families and communities across the region, and gave us some of the most significant advocacy material of the visit, discussed below.

Men's Walk and Talk. Jordan Meehan and Chris Bennett described a mutual physical activity model for men's mental health, with high rates of community access and a clear need for accessible community supports and mutual activities around it.

The Compass House. Susan McHugh and her team welcomed us into this community-led peer centre, where we spent extended time with staff and community members. People can access a supportive peer community centre led and influenced by the community attending it, participate in meaningful self-selected activity, and receive practical, flexible support and advocacy without NDIS funding.

Gumbi Gumbi. This Aboriginal community-controlled alcohol and other drug recovery service closed out the visit, speaking to the intersections of AOD recovery, mental health and First Nations identity. No politicians were engaged on this visit.

Themes and Lived Experience Voices

Justice system exits set people up to fail. Workers we met described people "released at 4:30–5:00 pm on Friday with no money or accommodation with no immediate access or referral to supports", release conditions that "force them back to situations where they are offending or attend mental health services in crisis", and people who "get picked up over the weekend of their release and have to serve the remainder of their sentence plus new charges that were avoidable". Housing, psychosocial support, mental and physical health care and income support are not in place before release on parole, and people are expected to have their needs met without any support in place. These are not adverse events. They are designed outcomes. This evidence directly strengthens the concerns we have raised about criminalisation and community safety legislation.2

We heard a clear preference for a block funding model that provides practical support, flexibility and assertive outreach for people experiencing psychosocial issues. The current system relies on NDIS eligibility and proof of disability to access needed supports, which is ineffective and creates substantial barriers for people to get help and remain in community without returning to jail or hospital. We heard calls for a specific stream for intersectional mental health and criminalisation within foundational supports, and an urgent need to prevent ongoing harm. There is also ambiguity across multiple agencies about what psychosocial support actually is, and who is responsible for funding it.

Unfunded, relational, peer-led support is keeping people out of hospital. At Compass House, almost every community member we spoke with said the staff and community had kept them from needing to attend hospital to cope with distress and symptoms, something that had previously been a regular occurrence for many. People spoke of loneliness and isolation before attending, and of feeling safer around others with similar experiences. This unfunded

2 Mental Health Lived Experience Peak Queensland, Submission to the Justice, Integrity and Community Safety Committee, Parliament of Queensland, *Making Communities Safer Bill 2024* (December 2024) https://mhlepq.org.au/wp-content/uploads/2024/12/MHLEPQ-Making-Communities-Safer-Bill-FINAL.pdf; Mental Health Lived Experience Peak Queensland, *Response to the Queensland Safety Priorities in Mental Health, Alcohol and Other Drugs Care* (May 2026) https://mhlepq.org.au/wp-content/uploads/2026/05/Response-to-the-Qld-Safety-Priorities-in-MHAOD-Care.pdf.

support has enabled many to improve their living situations and independence and remain out of hospital long term. These supports are relational and enduring, and community members contribute by mutually supporting others.

Rosa, a community member, spoke about her lifelong mental health issues beginning with a diagnosis and hospitalisation at ten years old, followed by extended hospital stays multiple times a year for most of her life. Rosa has not needed the hospital since receiving support and connecting with the community at Compass House. When the local hospital and health service and the NDIA assessment process would not recognise her experiences of severe DID, it was unfunded advocacy and support from Compass House that enabled her to secure housing and appropriate NDIS supports. Rosa is more than happy to provide statements and quotes detailing her struggles with mental health systems for advocacy or campaigns.

The cost of this model is carried by the people providing it. It is possible only because of a high tolerance for financial risk, a low CEO salary, and outright ownership of the properties used. The CEO reported being personally out of pocket $380,000 supporting one participant with high needs. We also heard that it is difficult to get quality, practical external training, and that recent training offered by the QMHC had not been useful for peer workers or for the people they support. Peer-led spaces like Compass House, alongside Happy Chat in Stanthorpe and The Junction in Cairns, are exactly the community-led models our safe spaces advocacy seeks to resource properly.3

Culturally safe support is scarce. We heard that the NDIS is not meeting the needs of First Nations families and communities, especially those with psychosocial issues. There is huge stigma and self-stigma about mental health, compounded by systemic racism and child safety policies that perpetuate the removal of children from families and the destruction of culture, a harm we have addressed directly in our submission to the Commission of Inquiry into the child safety system.4 There are language barriers and a complete lack of translation services for First Nations language users, a lack of accessible services due to remote isolation and unsafe cultural practice, and colonising clinical mental health services that leave no room for culturally appropriate understandings of mental health experiences. Aboriginal community-controlled organisations that work in holistic and culturally safe ways create better outcomes for First Nations people, and face reduced funding while doing it. That is not a detail. It is a direction.

Recovery from alcohol and other drugs needs community, not just clinics. We heard about too few services and healthy community activities for people to access while in town, difficulty accessing housing, constant financial stress, and stigma around addiction that makes meeting eligibility requirements for psychosocial supports like the NDIS difficult. We heard of the need for peer workforce training that navigates the intersections of AOD recovery, mental health and First Nations identity. Repeated failure in accessing supports means people with lived experience stop trying. Community-based solutions built on mutual activity, including sports, can provide a safety net.5

Men's mental health needs different doorways. Men's Walk and Talk reflected that identifying with mental health issues and seeking support is hard for men in regional areas. Drinking and substance use are common and more acceptable coping strategies than seeking help. Mutual physical activity is a more acceptable way to seek support, and community activities about mental health help break down stigma and self-stigma. We also heard of funding complications with the NDIS and NDIS-funded participants, and that there is not much practical support for participants outside the activity itself.

The peer workforce is growing against resistance. Across this visit we saw a workforce meeting institutional barriers and historic ways of thinking that do not appreciate the role and benefit of peer work. We left flyers and information for member recruitment, and will send critical thinking resources for lived experience advocacy.

General Remarks

3 Mental Health Lived Experience Peak Queensland, *Safe Spaces Capability Statement* (Capability Statement, July 2026) https://mhlepq.org.au/wp-content/uploads/2026/08/Safe-Space-Capability-Statement-MHLEPQ-July-2026.pdf; Mental Health Lived Experience Peak Queensland, *Safe Spaces Lived Experience Policy Roadmap* (Policy Roadmap, July 2026) https://mhlepq.org.au/wp-content/uploads/2026/08/Safe-Space-Lived-Experience-Policy-Roadmap-MHLEPQ-July-2026.pdf.

4 Mental Health Lived Experience Peak Queensland, Submission to the Commission of Inquiry into the Queensland Child Safety System (March 2026) https://mhlepq.org.au/wp-content/uploads/2026/03/MHLEPQ_Commission-of-Inquiry-into-the-Child-Safety-System.pdf.

5 On the health impacts of alcohol and other drugs and the need for community-based responses, see Mental Health Lived Experience Peak Queensland, Submission to the Inquiry into the Health Impacts of Alcohol and Other Drugs in Australia (May 2026) https://mhlepq.org.au/wp-content/uploads/2026/05/MHLEPQ-Health-Impacts-AOD-Cth-FINAL.pdf.

The systemic patterns from this visit are clear: a lack of culturally safe crisis response options; increased need for relational navigation and transition support in regional services; people with psychosocial disability unable to meet rigid diagnostic thresholds despite needing intensive support; longstanding community mental health programs being defunded as funding transitions into the NDIS; an individualised funding model that undermines the holistic, wraparound support communities actually provide; and weak coordination between the NDIS, corrections, public mental health and community services, leaving people cycling between hospitalisation, incarceration and homelessness.

Our advocacy threads arising from this visit: a foundational supports stream for people at the intersection of psychosocial disability and the justice system; block-funded, flexible, outreach-oriented psychosocial models that reduce reliance on strict NDIS eligibility; culturally safe, trauma-informed approaches in funding design and service delivery; and sustainable peer workforce expansion through secure funding, role recognition, and relevant training and supervision.

Short-term follow-up. We will provide targeted advocacy to raise awareness of poor-quality NDIS and SILS provider practices, particularly inadequate nutrition, unsafe living environments and unskilled staff. We will distribute MHLEPQ engagement and critical thinking resources to community clubs and peer work teams to strengthen advocacy capacity. We will maintain and strengthen relationships with First Nations and community-led organisations. We will confirm lived experience representation within our membership for justice-involved and criminalised populations, and recruit new members where our membership does not yet hold that expertise, so our advocacy supports people who are victimised and discriminated against by justice and carceral systems because of their mental health experiences. And we will gather personal statements, including from Rosa at Compass House and Geoff at the Seniors Club, to inform future advocacy and submissions.

Long-term advocacy threads. On NDIS psychosocial supports and funding reform: a foundational supports stream for people with psychosocial disability, particularly those intersecting with the justice system; block-funded, flexible, outreach-oriented models that allow continuity of care and reduce reliance on strict eligibility; and culturally safe, trauma-informed approaches in both funding design and service delivery. On system integration: improved coordination between the NDIS, public mental health, housing, corrections and community services, with relational navigation and assertive outreach in regional and remote areas. On the peer workforce: sustainable expansion through secure funding, role recognition, and training and supervision that peer workers themselves describe as useful, which, as we heard at Compass House, is not currently guaranteed.

We also learned something about ourselves. Engagement reached a wide range of services, organisations and community members, and strengthened awareness of MHLEPQ and PPB services, resources and membership. But future regional trips should involve more collaborative planning, clearer consultation objectives defined in advance, and paid consultation opportunities, so that community members are compensated for the expertise they contribute. The people of Rockhampton gave us their time and their truths. It is now our responsibility, and the responsibility of the governments we advise, to honour them.

Finally, an invitation. If you live in Rockhampton or Central Queensland and have lived experience of mental distress or suicidality, membership of MHLEPQ is free, and your voice would strengthen everything in this report. Join us, and help us make sure the next decision about these systems is not made without the people who live them.

Related MHLEPQ Advocacy

Readers of this report may find the following MHLEPQ publications useful. Each connects directly to what we heard in Rockhampton, and all of our submissions are available at our website.

- Mental Health Lived Experience Peak Queensland, Submission to the Justice, Integrity and Community Safety Committee, Parliament of Queensland, *Making Communities Safer Bill 2024* (December 2024) https://mhlepq.org.au/wp-content/uploads/2024/12/MHLEPQ-Making-Communities-Safer-Bill-FINAL.pdf: our warnings about criminalisation and its consequences, borne out by what Bridges described.
- Mental Health Lived Experience Peak Queensland, Submission to the Commission of Inquiry into the Queensland Child Safety System (March 2026) https://mhlepq.org.au/wp-content/uploads/2026/03/MHLEPQ_Commission-of-Inquiry-into-the-Child-Safety-System.pdf: the harms of child removal policies raised by CQID.
- Mental Health Lived Experience Peak Queensland, *Safe Spaces Capability Statement* (Capability Statement, July 2026) https://mhlepq.org.au/wp-content/uploads/2026/08/Safe-Space-Capability-Statement-MHLEPQ-July-2026.pdf: the case for resourcing peer-led spaces like The Compass House.
- Mental Health Lived Experience Peak Queensland, Submission to the Inquiry into the Health Impacts of Alcohol and Other Drugs in Australia (May 2026) https://mhlepq.org.au/wp-content/uploads/2026/05/MHLEPQ-Health-

Impacts-AOD-Cth-FINAL.pdf: community-based AOD responses of the kind Gumbi Gumbi called for.