Stanthorpe Rural Consultation Report

Regional Relationships and Engagement | August 2025

Date: August 2025

Staff: MHLEPQ / PPB engagement team

Focus of visit: Happy Chat community group; Regional and Rural Mental Health Collaborative; Lifeline Farmers Hotline

Content note: This report discusses experiences of mental distress, suicidality, psychiatric hospitalisation, and seclusion and restraint. Please read with care, and reach out to your supports if you need them.

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 Stanthorpe Area

Stanthorpe is the principal town of the Granite Belt, in the Southern Downs region of Queensland, around three hours' drive south-west of Brisbane on the New South Wales border. We acknowledge the Kambuwal people, the traditional custodians of the Granite Belt, whose country connects with that of neighbouring peoples including the Ngarabal, Jukambal, Githabul and Bundjalung. Sovereignty was never ceded. Rock art and ceremonial sites across the district, including near Amiens, hold tens of thousands of years of continuing culture, and the disruption of that culture through colonisation is part of the story of distress and disadvantage in this region today.

At around 810 metres above sea level, Stanthorpe is Queensland's highest and coldest town. It is home to approximately 5,500 people and a wider district economy built on horticulture, viticulture and grazing, supported by a large seasonal workforce. Like many rural communities, Stanthorpe carries the compounding effects of drought and water insecurity, distance from specialist services, an ageing population, and an absence of public transport. Clinical mental health services are limited, often located hours away, and lean heavily on telehealth and visiting workforces. That makes community-led and peer-led supports critical to local wellbeing.

Services and Communities We Engaged With

Happy Chat: a community and peer-led mental wellbeing model. Our visit centred on Happy Chat, a lived experience-led community group bringing together people with personal experience of mental distress, families, carers and supporters, and local service providers to build connection, mutual support and stronger social networks. Happy Chat was publicly funded for the first three years of its existence. It has since relied on unpaid community leaders, people who were previously accessing the service for support, volunteering their time.

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

Happy Chat's support extends well beyond its weekly community meetings. The group helps people navigate housing and homelessness, financial and legal issues, food insecurity, employment pathways, social isolation, and the services and supports that are meant to help them. Mutual activities, including a community garden, shared cooking and a community-run bookshop, create purpose, skill-building and social connection. Happy Chat is an effective working example of psychosocial support, and demonstrates what community-led foundational supports and social prescribing models could look like in practice.2

Leadership and sustainability. When grant funding ceased, Helen and Frank[3] stepped in to keep Happy Chat running, recognising the group's critical role in the community. Both have lived experience of mental distress. The group continues to operate on intermittent, short-term, insecure grants. Because of its impact, local funded health services frequently refer people needing complex psychosocial support into the group, despite it having no paid staff and no financial sustainability. The funded system leans on Happy Chat. It does not pay for it.

Regional and Rural Mental Health Collaborative. Our presence in Stanthorpe meant Helen was able to organise an initial mental health collaborative meeting with service providers, including disability employment services, clinical and community mental health providers, private practitioners, staff establishing the new Medicare Mental Health service, alcohol and other drug recovery support facilitators, and suicide prevention services supporting primary producers.

The collaborative was itself evidence of something we see too rarely: a community organising its own coordination because no one is funded to do it. It took a volunteer-run peer group, not a commissioning body, to get the region's disability, clinical, community, AOD and suicide prevention services into one room. The willingness was always there. The infrastructure was not.

Lifeline Farmers Hotline. We met Ray and Marie, who support farmers in distress. Ray is a former farmer and mental health nurse with lived experience of suicidality. As the senior nurse unit manager in charge of the Redland Hospital mental health unit, Ray eliminated the use of seclusion (solitary confinement) and restraint using the Safe Wards strategy developed in the UK. His experience directly informs our advocacy for the elimination of restrictive practices in Queensland.4 Marie has lived experience as a primary producer, and of the mental distress experienced by women raising families in rural communities where natural disasters and isolation are part of life. No politicians were engaged on this visit.

Themes and Lived Experience Voices

Community-led support prevents crisis. We heard consistently that the mainstream hospital system did not support people's holistic personal recovery, and was often retraumatising and restrictive. Significant mental health learning and improvement came instead from the social connection, practical support, mutual peer support and purposeful activity offered at Happy Chat. The group's non-clinical, community-based model kept people from reaching crisis point, reducing demand on hospital and crisis services. Among the voices we heard:

- **Ending more than ten years of loneliness and isolation.** A man who had been living in isolation outside Stanthorpe for more than a decade, while frequently experiencing hospital admissions for suicidal crisis and distress, told us that Happy Chat had addressed his loneliness. He has not had to access the hospital for crisis support in the five years since attending the group consistently. The practical support and advice provided through the group led to him successfully improving his health and living standards, and supported him to navigate other essential services and systems.
- **Breaking the psychiatric inpatient cycle.** A young artist with experiences of psychosis and a recent history of extended psychiatric admissions was able to break that cycle after joining the group. The practical support to workshop and navigate living situations, income support and health appointments helped stabilise her life. She told us the reassurance and connection available from the community when needed was "life changing". With support from peers she self-advocated for medication adjustments, sought part-time employment, and stabilised

2 MHLEPQ has argued for community-led, self-referral supports of this kind as part of the safe spaces reform agenda: 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.

[3] The names of individuals in this report have been changed to protect their privacy.

4 Mental Health Lived Experience Peak Queensland, *Advice on the Restrictive Practices Health Services Directive* (Advice to Queensland Health, 23 September 2025) https://mhlepq.org.au/wp-content/uploads/2025/12/MHLEPQ-Advice-on-Restrictive-Practices-HSD-23-September-2025.pdf.

her life. At the time of our conversation she had not needed the hospital since joining, something that had previously been a regular occurrence.

- **Improved outcomes for participants and carers together.** A woman with repeated long hospital admissions built her resources to cope with depression and increased her emotional regulation after joining. Her husband, who is also her carer, was able to attend work more regularly knowing she had peer support available if a situation arose. He told us he had increased his own knowledge of mental health, and found hope and support himself through connecting with peers in the group.
- **From grief to peer work employment.** A widow who joined with her daughter used Happy Chat to process her grief and loss. The group enabled her to complete a Certificate IV in Mental Health Peer Work, using Happy Chat for her student placement. Finding a placement is often the barrier that stops people in regional, rural and remote areas completing the qualification. She has now gained employment as a peer worker and has a support network in her community.
- **Reducing barriers to income support.** A participant had been applying for the Disability Support Pension on and off for eight years. Happy Chat supported him with financial advice and food relief, significantly improving his living situation, and helped relieve his distress and loneliness. With assistance he found the motivation to keep pursuing his claim, compile letters of support, and access clinical records to evidence it.

One line from these conversations deserves to stand alone, because it is the entire case for this model in a sentence:

"The reassurance and connection available from the community when needed was life changing."

The system's gaps are structural, not accidental. This visit surfaced consistent themes. Mainstream mental health approaches in the region are not trauma-informed, therapeutic or holistic. Service access is limited by narrow eligibility criteria and capacity constraints. Services are often located hours away from the communities they are funded to support, and public transport is non-existent. High clinician turnover disrupts continuity of care and relationships. Over-reliance on telehealth is a barrier to relationship-based support, and many people disadvantaged through their mental health experiences do not have access to the internet or computers.

Happy Chat operates as a critical, unfunded "third space" in the community. Local services regularly refer clients to the group and receive referrals from it, and it performs an informal navigation and coordination function. Many local providers at the meeting have their own lived experience of mental distress that shapes their practice. We see the same pattern in communities across Queensland: peer-led and community-led spaces like Happy Chat, The Compass House in Rockhampton, and The Junction in Cairns quietly holding up the funded system around them.

Rural communities need relationships, not rotations. Ray and Marie were clear that when offering services to rural communities, their lived experience was essential to developing meaningful engagement with communities that services struggle to reach. We heard that these communities are not best served by telehealth or fly-in fly-out workforces, because rapport and cultural context cannot be built from a screen or a departure lounge. Ray's account of eliminating seclusion and restraint at Redland Hospital also matters well beyond Stanthorpe. It is living proof that restrictive practices are not inevitable, that safe ward design and relational practice can replace force, and that the elimination agenda we have put to Queensland Health is achievable in practice, not just in principle.

Lived experience is already leading the region's services. One of the quieter findings of this visit was how many local providers at the collaborative meeting have their own lived experience of mental distress, and how directly that experience shapes their practice and their understanding of the benefits Happy Chat provides. The lived experience workforce in rural Queensland is not hypothetical. It is present, capable and largely unrecognised, and it is exactly the workforce that Queensland's peer work and Better Care Together commitments should be resourcing.

General Remarks

Happy Chat matters for Queensland's disability and mental health reform agenda for four reasons. It demonstrates a cost-effective, preventative model that reduces reliance on hospital and crisis services and takes pressure off already stretched rural first responder, justice and health services. It aligns with state strategies for recovery-oriented, community-based, lived experience-informed care and the peer workforce goals identified in Better Care Together. It supports community-driven solutions that address the social determinants of health and build capacity within the community. And it delivers measurable outcomes for the Stanthorpe community despite having no stable funding. These are precisely the

foundational supports we have called for in our national disability advocacy.5

Investment in this model would secure ongoing operations for a proven and well-accessed service with deep community links. It would enable expansion to support more community members. And it would build lived experience workforce capacity through peer work placements, employment and leadership opportunities. It keeps people well. It is held together by two volunteers.

The economics deserve to be stated plainly. The people whose stories appear in this report were, between them, regular users of hospital crisis care, psychiatric inpatient beds, and emergency services. Most have not needed those services for years. The support that replaced them costs a community garden, a bookshop, a weekly meeting, and the unpaid labour of two people with lived experience. No serious reading of that ledger concludes that Happy Chat is unaffordable. What is unaffordable is letting it fail and buying the hospital admissions back.

Our follow-up from this visit has three parts. First, we will maintain the relationship with Happy Chat and support the continuation of the Regional and Rural Mental Health Collaborative that our visit helped convene, because coordination in rural regions depends on relationships more than structures. Second, we will draw on the evidence gathered here, the member stories, the provider consensus, and Ray's elimination of seclusion and restraint, in our submissions and advice on foundational supports, safe spaces and restrictive practices. Third, we will invite Happy Chat members into MHLEPQ membership, so that Stanthorpe's voices are inside the rooms where policy is made, not just quoted in reports about them.

We will continue to advocate for secure funding for community-led psychosocial supports in rural Queensland, and we will keep drawing on Stanthorpe's example, alongside peer-led safe spaces and community centres elsewhere in the state, when we do.6 We leave this report with a simple test for funders: would this support work for me, and why should Stanthorpe settle for less?

Finally, an invitation. If you live in Stanthorpe or the Granite Belt 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 rural mental health is not made without the people who live it.

Related MHLEPQ Advocacy

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

- 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 evidence base for peer-led and community-led spaces like Happy Chat.
- 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: the reform pathway for funding them.
- Mental Health Lived Experience Peak Queensland, *Advice on the Restrictive Practices Health Services Directive* (Advice to Queensland Health, 23 September 2025) https://mhlepq.org.au/wp-content/uploads/2025/12/MHLEPQ-Advice-on-Restrictive-Practices-HSD-23-September-2025.pdf: the elimination agenda that Ray's work at Redland Hospital proves is achievable.
- Mental Health Lived Experience Peak Queensland, Submission to the Review of the *Disability Discrimination Act 1992* (Cth) (24 October 2025) https://mhlepq.org.au/wp-content/uploads/2026/08/DDA-Review-Final_24_10_2025.pdf: our case for foundational supports beyond the NDIS.

5 See Mental Health Lived Experience Peak Queensland, Submission to the Review of the *Disability Discrimination Act 1992* (Cth) (24 October 2025) https://mhlepq.org.au/wp-content/uploads/2026/08/DDA-Review-Final_24_10_2025.pdf.
6 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.